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MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

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Thoughts about therapy today

I have wondered what might be the real reason for the current tremendous preoccupation with Zen Buddhism and other oriental philosophies of life. Is this a manifestation of our interest in therapy, or could it indicate some feeling of dissatisfaction with contemporary therapy? What is the real reason that so many psychoanalysts are browsing in the literary and philosophic pastures of existentialism? Or in the fields of ethics and systems of values? Why are some analysts placing so much emphasis on sociological structures, real or ideal? What lies behind the recourse to the mystical? Or the constant reference to the "I-Thou" relationship as the cornerstone of therapy?

I believe that a good number of today's analysts who are delving into other fields do so to expand their horizons and to acquire new therapeutic insights. But I also believe that there are many analysts today deeply affected by what I would call, until I can describe it better, a kind of therapeutic pessimism. It is the reverse of the therapeutic optimism with which I believe most of us entered into this terribly difficult profession. I don't mean to imply for one minute the simple optimism that one can successfully treat all kinds of mental illness or every patient that might come for treatment. I have in mind the spirit which gave full recognition to people's need for psychological help but also believed that a therapist could attain some degree of sureness about how he was working and what he was working toward. I suppose that by therapeutic pessimism, I really mean a group of feelings possessed by an analyst, feelings of uncertainty about psychological theory, un-

Dr. Schaffner, who is a psychoanalyst in private practice in New York City, presented this paper May 19, 1958 as a presidential address before the William Alanson White Society.

certainty about psychological illness, about human nature, about human health, uncertainty about therapeutic goals, even uncertainty about what one has the right to regard as therapeutic success. I believe that many an analyst has felt a lack of foundation, direction or clarity in his own attitudes towards his patients and his work, and that for many it has meant the difference between satisfaction or dissatisfaction with one's chosen career. I believe that many have experienced a kind of major disappointment, which it has been difficult to share with others, especially since they were not sure whether any clarification was to be had. It is my observation that gnawing feelings of therapeutic unclarity and inadequacy and helplessness have been quite prevalent, though usually unspoken, and that these feelings may even have been connected with certain tensions and dissensions that superficially seemed quite unrelated.

I do not feel that the pessimistic analysts have lost their basic hope or faith in psychoanalysis as such, but rather that they have at times become deeply discouraged. They have profoundly missed a sense of definition, of precision, of process such as they feel is available in other sciences—all the more troubling, perhaps, because of their strong sense of responsibility toward the lives of their patients. In our field of psychoanalysis it is not easy to know where to turn for one's answers. There are many books and there are many answers. The profusion itself is disconcerting. Often the system-builders merely preach their own private doctrines. Usually his supervisors turn out to be the psychoanalyst's best resource. Many of them have found satisfactory working answers for themselves. Some supervisors are excellent at communicating these answers; some do not quite have the words or the formulations with which to communicate them to others.

Even Frieda Fromm-Reichmann, who was certainly a therapeutic optimist in the sense that I used the phrase earlier, had considerable worry about teaching others what she knew. Her brilliant and ingenious responses to patients were not haphazard or quixotic; they had a consistent basis in her way of viewing life and disease, and in her concepts of stimulating healthier reactions. Still she felt she had not yet found the way, the proper words, the appropriate psychological units, with which to explain to others her own therapeutic manoeuvres. In the fall of 1955 she told me that she felt the only ultimate hope lay in helping each young therapist to free and develop his own intuition. The next year, when she was in Palo Alto, she began to feel a bit more hopeful about methods of communicating to others what she herself knew and what she was doing in the therapeutic process.

Perhaps the simplest way of trying to express the undercurrent of insecurity about therapy would be to say that somehow it does not seem to be "true to life," that in some ways it fits and then in other ways it does not, that the *theory* seems to satisfy, but in application it somehow falls short, that it somehow lacks psychological realism. I have often had the impression that the current search into philosophy, Zen Buddhism and existentialism, represents partly a flight from discouragement, but may also represent one kind of positive attempt to find a way to view patients more in keeping with life as we feel it in ourselves. Some good undoubtedly has come from the search. The comparison of our points of view with any other, especially one as different as Zen, also has a particularly encouraging effect, since it emphasizes that one is to go on trying and trying, no matter how intricate and difficult the task, partly because of the joy of experiencing one's un-

known capabilities, but also because one will ultimately find the solution within oneself. Zen stresses learning without excessive dependency upon one's teacher, and by implication enables one to ignore frustration in self-disciplined pursuit of solutions to life's puzzles. The particular puzzles presented, however, have often puzzled me; they seemed to be an evasion rather than a meeting and facing of life.

In Martin Buber's philosophy, if I understand it correctly, the image again is not quite lifelike. There is a heart-warming appeal to human beings to speak out to one another, to trust one another. Certainly Buber stresses the importance of direct confrontation and communication on the emotional level. It seems to me that he speaks movingly for all those who have lived in some form of isolation and despair, whether it be isolation caused by hostility from outsiders or isolation caused by fear from within. He knows well the despair stemming from the seeming inability ever to break through the barriers of hostility. He speaks with the conviction of a man who no longer has to live alone, because he has found through an act of will or faith the means to live with other human beings. It is a crusade for trusting vibrant contact, without which a man cannot have a full life. It might be perilous, however, to feel that the direct emotional I-Thou contact can really restore a sick human being or in itself solve life problems. In fact, in today's world some problems might even be characterized as caused by an overabundance of I-Thou contact. The various mystics, I feel, describe experiences which doubtless had their origin in real life events, but it has always seemed to me that the real meaning or helpfulness of their experiences were lost because of the inability of the mystics to analyze and describe clearly what had taken place. Too often we are lured by the exoticism of an experience which we cannot examine critically because we have not been given the means to understand it at all.

Perhaps the search into existentialism uncovers something a bit closer to life as we feel ourselves to be living it, closer certainly than the life pictured by the early Freud. For example, mothers are differentiated individuals and not all similar because they are all mothers; the absolute starts to give way to the relative. In existentialist literature, authority topples from its position of unassailability, and tends to emerge as weak and corruptible. Life is worth living, not for the sake of deity, virtue or afterlife, but for its own sake, for its own intensity, its own experience of feeling and being. My opinion is that the existentialists performed a valuable service in starting to free contemporary thinkers from the shackles of philosophic, ethical and religious systems that were keeping scientists and laymen alike from seeing man more clearly and more realistically. On the other hand, they seem to have had one major bias of their own; their bitter 20th-century disillusionment, which creeps into their view of man. Most of the existentialist descriptions of life are so terrifying that one feels like congratulating those poor souls who braved survival at all. In some ways I believe the existentialists were busy fighting a feeling that it might be better to be dead, and that this preoccupation with the question of the worthwhileness of living may have caused them to neglect some other aspects of being alive.

This brings me now to my main point: that instead of looking elsewhere, to other cultures and other centuries, we might more profitably look at our own approaches to psychoanalytic therapy in order to locate the origins of our uncertainties, and then discuss how we might resolve them.

A major source of confusion, it seems to me, is that we have been expecting too much from the concept of interpersonal relations. It is of course the hallmark of the Sullivanian school. We know its historical importance, how it liberated psychiatric thought from the early mechanistic picture of a human being unfolding and developing apart from other human beings. We know too its usefulness as a concept showing the reactions of the child to significant figures, as the basis for the formation of the child's personality and his later patterns of relationship to other people. We also know Sullivan's theories about the self, the self that reacts to the stimuli from other persons, and the self-system.

But somehow, it has seemed to me, the emphasis in our teaching and speaking about patients has been placed primarily upon the quality of interpersonal relations that have influenced a patient, on the quality of interpersonal relationship that he brings about, or that he must deal within his present life. It seems to me that we have been too prone to deal in the therapeutic situation with the interpersonal relationship as such, instead of coming to grips with the man and especially with his picture of himself. I am not implying that this is Sullivan's original conception; I do imply that somehow, with the passage of time, the emphasis has shifted, and that as a consequence our understanding of patients and our therapy of them has suffered.

The fundamental force that accounts for behavior and interpersonal relations of any kind, I feel, is really the quality of feeling within the self, about the self. No amount of description, discussion or explanation of interpersonal relationships can possibly be therapeutically effective until we have understood the meaning of the interpersonal relationship to the self. We must first understand and relive the patient's tensions and distresses connected with his own self-picture. The same interpersonal facts can take place among ten very different persons, each of whom may interpret and react to them differently, in terms of the particular self-picture that he has.

Though I feel we are correct in seeing how interpersonal relations originally affected the self-picture, I believe that too often we mistakenly assume that when the "right" interpersonal relations have been restored, the self will also find itself changed and restored; therefore we concentrate upon the behavior of the individual rather than upon his feelings about his behavior. I believe we do not reach the core of a person as long as we deal mainly with what is going on between him and other people; we really touch him, the human being, only when he tells us how the interaction is affecting him.

For example, in treating a patient's hypersensitive reaction to criticism, how frustrating it would be both to the patient and ourselves if we centered our interest chiefly on the critical quality of his friends, or his irritating effect upon his friends, or why he happened to choose such friends. Not that these considerations are irrelevant, since often they contain necessary pieces of information. But they are not the basic issue. Discussion of such issues does not relieve the patient's hypersensitivity to criticism. It could hardly be considered adequate therapy if the net result of the discussion were merely that the patient sought an entirely new group of friends who were never critical, or withdrew from people once he discovered that they could be critical. Clearly it would be preferable to make sure that the patient understands that all human relationships involve criticism at some point, sometimes justifiable, sometimes not, and that his problem lies in the ways he reacts to criticism of himself, and

how he copes with it. Whether he can tolerate it, refute it, ignore it or profit from it will depend upon the effect of criticism upon his self-system. His first task must be to determine his own subjective reaction. What does criticism mean to him as a person? Does it destroy his self-esteem completely? Does he become frightened? If so, of attack or of abandonment, or what? Does he become paralyzed with fear or anxiety? How can he help but feel unfriendly toward his critics as long as criticism affects him in this particular way? How could he possibly appreciate the friendly, constructive intentions of some critics as long as he overreacts to criticism with total loss of self-esteem?

In my own experience I have found it unrewarding to approach the problem by dealing with the content of the criticism, or the quality of the interpersonal relationship with the critic, until *after* there has been some resolution within the patient of the specific meaning to him of criticism in general. Later we take up the special meanings to him of certain specific criticism. After his painful subjective reactions to criticism have been relieved, then I often find that the patient's interpersonal relations improve spontaneously, without specific notice, teaching or advice from me.

Most patients, I believe, have quite good pictures of what constitute desirable interpersonal relationships; they have been exposed to the same educational forces in the atmosphere as we. They do not behave in poor or strange ways for lack of education or models; quite the contrary, they often regard our references to desirable modes of relationship as sermonizing or patronizing. They come to us, not necessarily to be taught what patterns of living to follow, but mainly to find out what is obstructing them from living in the ways they know about and really care about. Moreover, when patients first come to us they generally already have a rather high degree of feeling of inadequacy. If we urge them to behave in a way at which they have already failed, we merely add to their self-criticism, feelings of inadequacy and discouragement. Instead of asking what is wrong with our telling them how to behave, they tend to interpret our misplaced teaching as further confirmation of their wrongness or lack of worth. In other words, by appealing in this way to their conscious standards, actually we further depress their self-picture. Dynamically, such lowering of the self-esteem leads away from change or progress, toward irrelevant argumentation, despair, rejection of psychoanalysis, hypercriticism of friends and self, and exacerbation of compulsive behavior. As we know, the self with the lowered self-esteem will become busy defending itself from further hurt, not with improving interpersonal relations.

Another example of misdirection of our emphasis and attention is shown in the discussions about love and loving relationships which not infrequently tend to occur early in a patient's treatment. The patient may tell the analyst that he does not feel sufficiently loving, that this is his problem and it is this that he wants treatment for; the analyst may comment to the patient in similar terms. To accept this problem at its face value, to my way of thinking, is to set the stage for therapeutic uncertainty and confusion of both analyst and patient. For by implication it suggests that in order to be mentally healthy it is necessary to be loving. How psychologically realistic is this? Are there not times when being loving is inappropriate or actually dangerous? Or, from another angle, is it necessarily a sign of intrinsic inadequacy in the person that at this current point in his life he is not yet able to feel loving? Need he feel

ashamed and apologetic about it? Or is it perhaps realistic and appropriate that a person with his particular background and his history was deprived by fate of those experiences through which he might have emerged a different person. Too often the patient is one who takes the blame for failing entirely upon himself, and develops the fear that he is not even worthy of being loved. It is this fear of being unworthy that can prevent him from offering his love to others, rather than any intrinsic inability to love. When he is relieved of his self-blame and his conviction that he would necessarily fail again, he will find his way to a loving relationship because he himself not only desires it but has become free to do so.

To carry this example one step further in order to illustrate psychological realism in approaching therapeutic matters, there is the vitally important matter of timing. It is a hard fact but perfectly true that at a certain point in time a patient may not be able to love, despite his wish and the analyst's hope for the loving potential to be liberated. It may be quite impossible at that particular point in their work together, simply because the patient has not reached the stage in his development where he would be ready for or receptive to such a relationship. An understanding by the analyst of developmental readiness can make all the difference between a patient dissatisfied with himself because he has not reached a stage that he in reality should not have reached yet, and a patient satisfied with his current achievements thus far and thereby encouraged to try for still greater goals of self-realization.

I have the impression that we do not view patients enough from the point of view of their own longitudinal development. We do this automatically when we think about children, perhaps thanks to the work of such people as Gesell and Ilg, who have accustomed us to concepts of growth and maturation in both physical and behavioral terms. In general, psychoanalysts have not paid enough attention to the table of psychological development first presented by Erik Erikson in his *Childhood and Society,* with the well-known diagram beginning with the stage of trust, moving through autonomy, initiative, etc., to end-stages of generativity and integrity. It is not his list or his definitions of particular stages that we need to take literally, but the basic concept of a natural sequence of personality development, no advanced stage of which can develop successfully if there is any serious disturbance, uncorrected, in a preceding developmental stage.

We psychoanalysts must make it our job to determine as early as possible in treatment where each person is on his own developmental line and which essential phase of his developmental line has become twisted up or knotted. For example, if a new patient pleads with us to discuss her questions about sexual relations, courtship and marriage, we should make every effort first to assess her psychological readiness to take up these questions. If we should discover that she has always been plagued with a feeling of physical and intellectual helplessness, has resultant overwhelming feelings of dependency, and has always resented people in general because they have not taken care of her as she thought necessary, we are likely to conclude that her psychosocial immaturity must be taken care of first. And we would feel it sounder to point out realistically—that is, therapeutically—that we do not deem her ready to cope with these matters until she has resolved some more fundamental ones. We do not find fault with her for not being ready to discuss other matters yet; on the contrary, we must indeed give her credit for having been

able to manage other aspects of her life as well and constructively as she has, considering the enormous handicaps under which she had been functioning. She can also be pleased with herself for asking for help when she must have hated to reveal her feelings of helplessness, and can be proud for postponing issues that must seem quite urgent and vital to her self-esteem. To learn that the analyst expects her to be able to tolerate this waiting may be therapeutic in itself since it implies his faith that she possesses this capability, although in her picture of her helplessness she might never have thought so. In this way the stage is set for realistic therapy—refusing to work at a level too advanced for the welfare of the patient, no matter how much she insists; instead, increasing her self-esteem so that she can accept the delay, even so far as accepting what she might at one time have considered to be humiliating. For if we do not succeed in maintaining the self-esteem of the patient at every stage in therapy there is grave danger of losing the patient's willingness to cooperate in the self-revelation that is necessary for further improvement.

I believe we shall all have to come round to thinking in much simpler concepts as therapists than we have been accustomed to so far. We have come into the practice of therapy at a particular time in history when the doors to the wonders of psychology have only recently been opened, when the world in a manner of speaking is still gaping and when, as usual, too much has been promised too soon and much too much is being asked of psychoanalysts by people in general and regrettably by psychoanalysts too. Many analysts, I am afraid, have been expecting the impossible from psychological therapy. One might say that they are attempting to be plastic surgeons of souls. To approach a human patient with such a concept of therapy not only grossly overestimates what we can actually do, but also maligns the basic concepts of therapy as we know them in the field of medicine: realistically, the doctor who treats a wound can never forget that he is but an assistant to nature, that his function is to learn first the properties and physiology of tissue, then the nature of healing, the conditions under which healing will proceed, the conditions which would interfere with it. Through all the means at his disposal he tries to provide the atmosphere, necessary tissue sustenance, guidance and protection that will liberate the healing forces of nature. He does not direct nature, as some psychoanalysts have been asked by our times to do. He studies the ways of nature, and he assists her.

I feel strongly that a large measure of insecurity and dissatisfaction among today's psychoanalysts may be traced to too heady a dose of psychoanalytic ambition, not enough emphasis on the natural difficulties in producing psychiatric change, and not enough solid foundation in the study of human nature and psychology.

If you were to ask me now, what do I recommend that we psychoanalysts study, I would start with a list something like this:

First, we psychoanalysts could become acquainted with the current exciting work in the field of animal behavior, as represented by Lorenz and Tinbergen in Europe, Schneirla, Liddell, Hess and Lehrman and others in this country. In particular, I think analysts would do well to read carefully the works of Beach at Yale and of Blauvelt and Richman at Syracuse.

Beach, for example, demonstrated the important point that a traumatic incident, so-called, may have extremely variable effects, from great to small, depending upon the previous history of the animal, the age at which the incident takes place, the relationships of the animal at the time it takes

place, as well as the quality, quantity and duration of the traumatizing. This is another way of indicating that it is not necessarily the real fact which is so telling in a human being's life, as its significance to him in terms of his past experience and present situation, the events going on in his life when it happens, and how well he has been able to cope with the traumatic fact.

Blauvelt's work on the relationship between mother-goats and their kids demonstrates superbly (as did also the work of Rene Spitz) the vital biological role of dependency. When the link between mother and kid is interrupted or even interfered with in the experimental situation, the young kids soon become ill and die. One needs no more than this to acquire a deep appreciation and respect for dependency needs in childhood, the powerful reactions to threats of loss of dependency, and the amazing efforts that children make to retain the relation while they need it.

Blauvelt and Richman are at the present time carrying out similar studies on the relationship between human mothers and their babies. This new work has already demonstrated the important point that instincts do not necessarily make it possible for nature to function smoothly from the start. Even in such an instinctual matter as nursing, both mother and infant need anywhere from two to five days of practice until their instincts can function smoothly and reciprocally together. The films showing the behavior of nurses in response to mothers and babies who are in the midst of working out the nursing relationship, and especially the nurse's responses to the anxious mother, make it especially clear that the therapeutic attitude is one that primarily relieves the mother's sense of failure, teaches her what to expect, permits her to discover her own rhythms and to feel capable in her own way of interweaving her rhythms with those of the baby. Blauvelt's work also shows that the least therapeutic method directs attention away from the real happenings between mother and infant by stressing an ideal interaction, which interferes with the natural process that is taking place and thereby deprives both mother and child of the trials and joy of the mutual activity.

It would no doubt please Harry Stack Sullivan if he could see that his basic theories about development via interpersonal relationships is finding such confirmation today in these experiments. We who follow him can be grateful to the animal psychologists for calling to our attention natural units of behavior which can be observed and studied easily, natural units of behavior which are equally applicable and useful in our own daily work with human beings. Dr. Blauvelt's descriptions of interaction are a model of non-teleological observation, which is always difficult to accomplish. Trying to follow her example could be of tremendous assistance in trying to see and to think clearly about the highly complex individual and social situations that we try to analyze.

There is also much for us to learn from the field of education. In the eager pursuit of the well-adjusted personality, with the eye too much on the end-result or goal, psychology and psychoanalysis, I feel, have tended to ignore basic units of behavior, basic processes which now need to be re-itemized and re-viewed. For some twenty years John Dewey has been out of fashion, but I think it would be profitable for all of us to re-read him from time to time. He was a contemporary of Freud's who really reads like a contemporary of our own. He bears re-reading especially for his perceptiveness about the elements of learning behavior and their larger relationships to life.

We might profit far more than we do from the research of Piaget on the nature of children's thinking. Without his work I for one feel that I could not have understood as well the seemingly fantastic interpretations and distortions that children normally make and unfortunately often carry along into their adult lives.

Lois Murphy's study of the development of children likewise seems to me a happy way of identifying the component parts and patterns in human educational development, making it easier for the analyst to observe the often relatively simple process underlying a complex adult interaction pattern.

To illustrate what I am referring to in the work of educators, we might take up the behavioral unit of "getting." To get, to fill a need, is the first ability every organism must learn. The appetitive drives form the psychological basis of both individual and social life. Considering the disrepute into which the appetitive "selfish drives" have fallen in western culture, it is remarkable how much man has managed to learn about his needs and how to meet them. In this regard the twentieth century has begun to reverse the trend. Thanks to the studies of Pavlov, Cannon and their successors, we know much more now about biological reactions to frustrations of appetitive drives, and about fear and rage.

It has become clear that one's psychological development begins in terms of getting and in receiving, that each human being goes through the pleasure of success or the tensions and frustrations of failure in getting. The first learning is in connection with getting. The first friendly feelings toward other people are usually in response to having been given to, the unfriendly toward those who refuse to give. The management of the natural reaction to frustration becomes just as essential to the development of the growing, learning organism as the learning of the capacity to get. You all know the significance for the child who has not learned that frustration will pass, or that his frustration is a normal though difficult experience, who experiences his own frustration as indicating weakness or inferiority in himself, who does not know when to accept frustration as final, or when to refuse to surrender to frustration. You know that the feelings of a child about his ability to get will have enormous bearing on his future feeling of capability and optimism; you know that what a child experiences in connection with frustration early in his life will have much to do with his future capacity to tolerate frustration when it is necessary or unavoidable. The early lessons about frustration bear a close relationship to the child's subsequent attitude towards authority-figures, and the child's own later capacity to assume authority over others. The variable effects of timing of early frustrations, quantities and objects of frustration, and the relationships to the people causing the frustration have great significance for the future inclination of the child to give to others, to expect and receive from others—in fact, whether or not to have anything to do with other people.

It is this kind of psychological function—reactions to getting and not getting—which need to be studied in full, and to be understood in this manifold determining relationship to mental health and mental illness.

The reactions to getting and not getting lead quite naturally into another frequent pattern of interpersonal relationship, the tug-of-war of getting, giving and refusing that may unfortunately develop into the pattern of parental inconsistency and tantrum behavior: uncertainty by the child as to what the parent really intends to do, pushing and testing by the child, angry sur-

render by the parent, ending perhaps in victory for the child but without joy in the getting.

Or again, starting with the fundamental psychological unit of getting and receiving, we can set out to describe how expectations arise, what expectations are regarded as normal, what happens when expectations are not met, the origin of the feelings, "This is not fair, this is not just," or "If you don't give me what I expect, you do not care for me," or "If you do not give me what I expect, then I must not be good enough," or "If you do not give me what I expect, then you are bad and you must be punished." With such building-stones we can also begin to explain neurotic needs, needs that do not spring from expectations based upon experience but arise from deficiencies in the self-picture.

There is also considerable room for clarification today of the real meaning of anxiety, a keyword in psychoanalytic thinking. Our thinking about words like tension, stress, apprehensiveness, fear and anxiety has not always been concrete or precise. Yet these words need to be given specific definition, so that analyst and patient can identify these feelings accurately, so that patients can incorporate the feelings into their daily living, use them constructively, tolerate them where necessary, or relieve them when possible. I personally am inclined to use the word "tension" in connection with unresolved action still in progress, or contradictory tendencies not yet resolved. I use the word "stress" in connection with the psychological and physical cost to the human being of tension and anxiety. I incline for my own purposes to use the word "apprehensiveness" to mean the anticipatory dread of the outcome of the unresolved. And I have come to use the word "anxiety" in a restricted sense, as the psychological and somatic accompaniment of an unsatisfactory picture of the self.

These distinctions are practical both in aiding the patient and in giving the analyst a firmer sense of direction in his strategy with the patient. Tension can often be borne better when people know that it is normal and expectable in a situation. Experience of stress and knowledge of its consequences provide additional incentive to a patient to make progress. Apprehensiveness is sometimes entirely appropriate and it is often important chiefly to help patients to know how well they will be able to function despite their apprehensiveness. As for anxiety, I have noticed a marked change in my own sense of security in dealing with patients since I have relinquished the antiquated concept of a free-floating anxiety, unrelated to one's body, one's self-picture, or one's relationship to other people. I am not inclined to believe that there exists any anxiety without cause. Usually I have found it valuable to learn more about the patient's situation, his reactions and interpretation of it, especially in terms of its effect upon his picture of himself and his welfare.

Continuing with suggestions that may be of help to psychoanalysts in attaining psychological realism, I feel a word about the use of anthropological studies are in order. We need more familiarity with the idea of culture—the group of conventions and patterns around which a group organizes its relationships, its communal living, its expectations, those aspects of life it overvalues or under-values, and those aspects of life it provides for or prohibits. We need to be quite clear about the overlapping between culture and the individual, to be able to recognize where the individual has indeed been influenced by his culture without being aware of it, or where the individual uses his culture to hide behind in

justifying behavior which really is of subjective origin.

We have probably not made as much use of anthropology as we might since most of it has been written about tribes so remote from us in time and cultural patterns that we have found it difficult to extrapolate. Yet there now is available knowledge of a few selected modern cultures which are important to know about because of the marks they have left on our own conglomerate cultures in the U.S. Today's psychoanalyst, especially if he is working and living in New York, could feel far more certain about meanings and origins of behavior patterns he is asked to deal with if he had obtained a working acquaintance of cultural patterns in the British Isles, Germany, Italy or Spain, the post-slavery Negro family, and the *stetl* culture of East European Jewry. Those of you who have already read the delightful book *Life Is with People* will know how infinitely useful it is for comprehending Eastern Orthodox Jewish culture.

In my own experience I have found that familiarity with at least one Slavic or Far Eastern culture is especially valuable in helping to free oneself from the tyranny of one's own unconscious cultural heritage. I should like to recommend at least one good course in comparative religions, for the same reason.

Last on the list of newer understandings that I feel might help to dispel therapeutic pessimism is the considerable amount of new information and interpretation offered in the area of interpersonal communication.

Communication, at its simplest, is how patients talk to us and how we talk to them. Much time is spent during our training as psychoanalysts on the history of psychoanalysis, the critique of psychoanalytic theory, personality structure and dynamics —all of which are necessary—but we spend proportionately far more time on them than on a very important course called simply "the initial interview," which in my opinion is vital to the training of an analyst. In it we get our basic notions about the necessity of observing and drawing some meaning from the finest occurrences, the slightest motion, the stance and gestures, the tone of voice as well as the words, spoken and unspoken. In this same course we also begin to learn the strategy of therapy, which must consist of what one says, how one says it, and what one does not say. In my opinion, it is a course that should begin in the first year of an analyst's training, should continue through each year of his training, and perhaps continue for some ten years after he has graduated. It should move on from the initial interview to the first month's interviews, interviews at times of crisis, interviews at times of lulls, interviews at times of progress, and so on till finally we come to interviews relating to the termination of therapy. There are many regularities in the natural growth of the psychoanalytic situation that could well be taught in class or seminar fashion, and that could include more of the modern knowledge about linguistics, kinesics and non-verbal communication.

It also seems to me that there is much more we can be taught about ways of *hearing* what the patient is saying, about different awareness of his sentences, what parts of his sentences and paragraphs to listen to. We could learn much more about what to expect, so that we could become more quickly aware of what is being omitted. No doubt we could also greatly shorten the time that therapy takes by increasing our efficiency in hearing what the patient is saying, and by increasing our competence in saying to him what will really help him more immediately. The

art of talking with patients can be better understood, better explained, given a more secure foundation that will support the psychoanalyst while he is working with his patient.

In conclusion, my last thought about therapy today is that most of us are trying to accomplish more therapeutically than we as a profession are ready and able to do. Undoubtedly we are overreaching ourselves, trying to achieve more than we know, denying ourselves the time in which to acquire from other areas of knowledge the very things we need.

It is often a very difficult profession; yet it has its rewarding sides. It gives us the opportunity to know many lives in three dimensions, to learn much about human beings, to help some of them with their problems. With many of our patients we can feel adequate and we can be pleased with them and with ourselves.

We necessarily complain about the many uncertainties under which we work. No matter how many of these uncertainties we clear up, there will certainly be more for a long time to come. It may be that as therapists we shall have to reach our own maturity in order to be able to tolerate our own special forms of incompleteness and uncertainty. As we become less anxious ourselves about uncertainty, we shall be freer to see our way in therapy more *surely*.

PAUL HAUN, M.D.

Attitudes about mental health

A cultural and psychodynamic appraisal

It would be a somewhat thankless task to add to the collection of statistics designed to show that the general public is skittish about mental illness, and that a distressingly large proportion of professional people share its views. If we are willing to accept this unpleasant fact as already demonstrated, we are free to speculate on why a few general practitioners of medicine display such alarming ignorance of mental disease, why little boys continue to scare each other by peeking into the windows of psychiatric hospitals, why a Broadway comedy can scarcely hope for success unless it has a few jokes about psychiatry, and why our friends and neighbors grumble about going into the hospital for an appendectomy but sink into soul-wrenching terror at the thought of a mental illness.

There is, I fear, no documented explanation for these sorry facts—no certain answer to the questions that they raise. A conjectural inquiry may, nonetheless, serve a useful purpose if it helps us recognize a new dimension of reality, and assists us in channeling some of our efforts in more promising directions.

I was vacationing at a remote but in no way inaccessible region of the mountains when I met George Hicks. He was a slight, wiry man in his middle fifties who worked in a small furniture factory tucked away among the pine trees. His home was comfortable although it lacked what we nowadays tend to expect in the way of electricity, plumbing and central heating. He and his

Dr. Haun, who is director of psychiatric education for the New Jersey Department of Institutions and Agencies, presented this paper October 30, 1958 at the 57th annual conference of the New Jersey Welfare Council.

wife worked their acre or two of ground less as a farm than as a kitchen garden and were able by this means and the exercise of reasonable thrift to stay out of debt and to own a second-hand car and decent clothes. George liked to hunt and fish but was not interested in travel for its own sake and had visited the county seat, a town of some 12,000, only twice in his life. He and his wife, members of the same church attended by the majority of their acquaintances, liked to visit their neighbors and have friends drop in for an evening's sociability.

George had stopped school in the fourth grade to help his father clear a piece of land and had never found the time to go back. He knew all the arithmetic he needed for his work in the furniture factory and for his occasional purchases at the store. He could read, although he habitually formed each word with his lips and kept his place on the page with a forefinger. On the infrequent occasions when he was obliged to sign his name, he did not write it but would draw it clearly and carefully like a picture. He was a dependable, careful worker who got on well with most people. Now and then someone asked his advice, and his opinions were usually respected.

The thing about George, however, was that he believed the world was flat. He had never mentioned it to me and felt no compulsion to persuade others to his view. It came out only after I had known him and his fellow workers at the factory for some little time, and they had gradually discarded some of their company manners. A rather disagreeable young man who enjoyed needling George whenever an opportunity occurred came out with it abruptly one day. George shot a lightning glance at me, ready to run for cover, while the young man who had been his tormentor prepared for a loud guffaw at George's expense. I must have been able to react in much the fashion that would have been expected had I been told that George was fond of cucumbers, because when I asked him how he had come to this conclusion he answered me candidly and quite adequately.

Mountain crests were obviously higher than valleys. Up was up and down was down. If the world was a sort of glorified baseball, it had a top and a bottom. It had up and it had down. It simply went against a man's daily observation that water could be made to run uphill. Unless the world was flat, all the water in the streams and in the oceans would naturally follow the laws of up and down and drain away something in the fashion of the Sherwin-Williams trademark in which big globs of paint are pouring down the sides of the earth and dripping off the bottom. To George the horizon was not the point at which the curvature of the earth became manifest. It was simply the limit of human vision. However far he had walked on his hunting trips, he had seen nothing spherical about the ground beneath his feet and every stream had obviously run downhill.

How about circumnavigation though? Didn't that put his theory in question? George grinned at this, and it was clear that he was still on familiar territory.

Here he was open-minded and felt that there were two possible explanations. First of all, it was hearsay. No one of his acquaintance claimed to have sailed around the world, and George had heard enough fish stories in his life to know that men were not above pulling your leg with a tall tale. He leaned more, however, to the thought that these people were self-deceived and that they had actually mistaken a circular journey on a planar surface for circumnavigation. Those who affirmed that the world was a baseball were stuck with the conclusion that China was directly under foot and, as a consequence, that Chinamen

walked upside down—a bit of nonsense which stirred George's risibilities.

It would have been easy to think of George as a fool or, at best, an eccentric. Yet there were certain uncomfortable consequences to this conclusion. In historical perspective a high percentage of humanity would have had to be lumped together as buffoons, including Sophocles and Alexander the Great, Mohammed and Julius Caesar. As late as the sixteenth century there were plenty of competent navigators who if they ventured too far from land were by no means sure that their vessel might not slip over the edge of the world into the measureless void beyond. In fact, I think we will have to give George credit for a greater measure of native intelligence than his tormentor. He came to an unfashionable conclusion based on a careful scrutiny of everything he was able to observe, of every fact he had at his disposal. His tormentor simply accepted the conclusions of other people without the vaguest understanding of how they had been reached. We'll return to George a little later.

I would now like to interpolate two pertinent passages from *The Witch's Hammer,* a book written by two Dominican inquisitors accredited by Pope Innocent VIII. It was first published in Cologne in 1489. Fourteen editions had been issued by 1520, and another 16 between 1574 and 1669. It was a sort of inquisitorial Blackstone, a handbook to which for some 200 years pontiff and king, bishop and judge made constant appeal in their struggle against witchcraft. How did Pope Innocent see the threat? In his Bull Summis Desiderates he says:

"It has indeed lately come to our ears, not without afflicting Us with bitter sorrow, that in some parts of Northern Germany, many persons of both sexes, unmindful of their own salvation and straying from the Catholic Faith, have abandoned themselves to devils, incubi and succubi, and by their incantations, spells, conjurations, and other accursed charms and crafts, enormities and horrid offences, have slain infants yet in the mother's womb, as also the off-spring of cattle, have blasted the produce of the earth, the grapes of the vine, the fruits of trees, nay, men and women, beasts of burthen, herd-beasts, as well as animals of other kinds, with terrible and piteous pains and sore diseases, both internal and external; they hinder men from performing the sexual act and women from conceiving, whence husbands cannot know their wives nor wives receive their husbands; over and above this, they blasphemously renounce that Faith which is theirs by the Sacrament of Baptism, and at the instigation of the Enemy of Mankind they do not shrink from committing and perpetrating the foulest abominations and filthiest excesses to the deadly peril of their own souls, whereby they outrage the Divine Majesty and are a cause of scandal and danger to very many."

The book deals exhaustively with every problem, with every difficulty that could be foreseen, discussing it, resolving it. Part One treats of the three necessary concomitants of witchcraft, which are the devil, a witch and the permission of Almighty God. Part Two treats of the methods by which the works of witchcraft are wrought and directed, and how they may be successfully annulled and dissolved. Part Three relates to the judicial proceedings in both the ecclesiastical and civil courts against witches and indeed all heretics.

In a chapter dealing with some of the more distressing examples of witchcraft we find the following case history. The authors write:

"A certain high-born Count, in the diocese of Strasburg, married a noble girl of equal birth; but after he had celebrated the wedding, he was for three years unable

to know her carnally, on account, as the event proved, of a certain charm which prevented him. In great anxiety, and not knowing what to do, he called loudly on the Saints of God. It happened that he went to the State of Metz to negotiate some business; and while he was walking about the streets and squares of the city, attended by his servants and domestics, he met a certain woman who had formerly been his mistress. Seeing her, and not at all thinking of the spell that was on him, he spontaneously addressed her kindly for the sake of their old friendship, asking her how she did, and whether she was well. And she, seeing the Count's gentleness, in her turn asked very particularly after his health and affairs; and when he answered that he was well, and that everything prospered with him, she was astonished and was silent for a time. The Count, seeing her thus astonished, again spoke kindly to her, inviting her to converse with him. So she inquired after his wife, and received a similar reply, that she was in all respects well. Then she asked if he had any children; and the Count said he had three sons, one born in each year. At that she was more astonished, and was again silent for a while. And the Count asked her, 'Why, my dear, do you make such careful inquiries? I am sure that you congratulate me on my happiness.' Then she answered, 'Certainly I congratulate you; but curse that old woman who said she would bewitch your body so that you could not have connexion with your wife! And in proof of this, there is a pot in the well in the middle of your yard containing certain objects evilly bewitched, and this was placed there in order that, as long as its contents were preserved intact, for so long you would be unable to cohabit. But see! it is all in vain, and I am glad,' etc. On his return home the Count did not delay to have the well drained; and, finding the pot, burned its contents and all, whereupon he immediately recovered the virility which he had lost. Wherefore the Countess again invited all the nobility to a fresh wedding celebration, saying that she was now the Lady of that castle and estate, after having for so long remained a virgin. For the sake of the Count's reputation it is not expedient for us to name that castle and estate; but we have related this story in order that the truth of the matter may be known, to bring so great a crime into open detestation."

As with George, who believed the world was flat, it is easy for us to feel a shocked abhorrence at a society which believed in demonic possession and burned miserable old women at the stake because they had been declared to be witches. Yet suppose, for the sake of argument, that witches do exist, that they do cast evil spells upon the innocent and are the proximate cause not alone of a vast amount of human misery, but of the eternal damnation of countless souls who, throughout eternity, will be doomed to unspeakable punishment. Would we not feel a pressing need to combat this terrible threat and to eradicate it root and branch? Would not our humanitarian consciences compel us to be exquisitely cautious in all that we undertook so that no innocent person was mistakenly punished, no hysteria created, no venal motives countenanced? It will interest you to know that this is the consistently reiterated theme of *The Witch's Hammer.* The sober and consistent insistence of its authors—Do not be impulsive! Make no mistake! Destroy only that which is surely evil! Grant only the basic assumption that witches exist and all the rest becomes necessary for the preservation of humanity. We will return to *The Witch's Hammer* a little later.

Having jumped from a hillbilly who believed the world was flat to medieval witchcraft, our next speculative flight is to the

comfortably rational year of 1898 and the publication of a novelette by Henry James. He came from a remarkable family and, through long association with his brother, William James, distinguished educator and psychologist, became interested early in his career in the quirks and oddities of personality. Dry facts uncovered in William's careful scientific investigations were seized upon and transmuted in the cold flame of Henry's artistic genius into quite remarkable works of art. The little book he published in 1898 called *The Turn of the Screw* is an exquisitely precise invocation of terror, a clinically exact anatomization of its specific qualities. I challenge anyone who is capable of having a nightmare to read it without experiencing a first-class attack of the creeps. Even to think of the children, Miles and Flora, of Miss Jessel and Mrs. Grose, or of red-haired Peter Quint is to feel our hearts begin to thump and our hair to prickle.

James' success in writing what to many of us is the one authentically terrifying book in the English language is reducible to a quite simple technical device. By his skill as an author he persuades us to believe in the reality of the people and the events he describes. He then whispers a hundred clues which might account for the whole affair and masterfully avoids weighting any of them in a fashion which would clarify the matter or cancel out all of the remaining hints. We are left to flounder helplessly from one speculation to another, each more horrifying than the last, and to find that none has sufficient solidity for us to feel that, bad as it is, we understand at last. For the time that we are under his spell, James compels us to face the unknown, the inexplicable, the incomprehensible, and it is this which is the essence of terror.

Each of us is born with a set of needs which must be met if we are to survive. Most of these we share with other forms of mammalian life: the need for air to breathe, for a degree of warmth, for food, for water, for sleep. None of these is peculiar to our species. Surprisingly enough, there is another need which is seldom mentioned, perhaps because it is so basic that it has escaped our attention. Although it is essential for human development, I would suspect that it is in or near awareness only among human beings. In this sense, it distinguishes the human organism from all other forms of life. Quite simply and quite obviously, it is the need for order, for a measure of predictability in ourselves, in our physical environment and in our relationships with other beings. In this frame of reference, man's entire existence from birth to death is an uninterrupted sequence of educational experiences. The initial lessons concern the difference between a leg which is attached to my body and a rattle which is interruptedly attached to my hand; between a noise and a mouthful of milk; between a mother and the odor of soap. Many years later the lessons may concern the difference between a proton and an electron, or between a note delivered through official diplomatic channels and an inspired editorial appearing in a government-controlled newspaper.

If the infant's hand became first a teddy bear and then a doorknob, and the next instance a noise of ringing bells all in a completely capricious and altogether unpredictable fashion; if all mothers were werewolves, now a bat, now a mote of dust, now the rustle of autumn leaves; if electrons obeyed no discoverable law and nations acted in a manner which could never be defined as probable or improbable, we would have arrived at chaos—and no human being can survive in chaos.

Although the examples I have used are extreme to the point of irrationality, they

illustrate the essential nature of the principle. When the titre of uncertainty in existence rises too high, human life becomes impossible. We walk confidently in the daylight because our past experiences which began in infancy and the stream of visual stimuli impinging on our brain assure us that the sidewalk will be solid beneath our feet. We grope and shuffle in the dark because we cannot predict what lies ahead—a precipice, a wall, or a highwayman.

If I believe my friend when he tells me that I am in the center of the Bonneville salt flats and that the ground is entirely without irregularity beneath my feet for miles in all directions, I will consent to run, tightly blindfolded, at top speed for whatever distance my wind holds out. This is faith which, in our search for order and predictability, is quite as serviceable as any other kind of evidence.

We are ready now, I think, for the conclusion. George Hicks needed a picture of the world in which to orient himself. The threat of slipping off a terrestrial sphere into free-floating space flight seemed, according to his best judgment and the direct testimony of his senses, an imminent possibility if the world was not comfortably flat and correspondingly stable. He felt insecure and doubtful with the one theory, comfortable and content with the other. His need for order and for predictability was answered if he accepted what clearly appeared to be the fact. He was satisfied with the opinion held by countless generations of his forebearers.

Pope Innocent VIII believed unshakably in witches, as did his contemporaries. Their existence allowed him to remain convinced of God's mercy and goodness. Their evil works explained a large chunk of the otherwise inexplicable. They were the reason why upright men were visited by disaster; why virtue was not always rewarded; why strange sicknesses attacked, as he says, "infants when in the mother's womb, beasts of burthen, herd beasts, as well as animals of other kinds, vineyards, orchards, meadows, pastureland, corn, wheat, and all other cereals." Belief in witches spared him and all men from a conviction, which in that day appeared as the only alternative, that God had created a capricious, unpredictable and chaotic universe totally lacking in order.

Henry James in his vignette of terror reminds us that we share with George Hicks and with Pope Innocent the same fear of chaos, the same need to have all that touches our lives, categorized by experience, by reason or by faith as somehow, someway susceptible to law; obedient even though obscurely to the dictates of order.

This, I suggest, may explain to some degree our queasiness about madness; our difficulty in accepting the mentally ill as ordinary folk victimized by their genes, or their environment, or their metabolism. Until day before yesterday leprosy gave everybody an attack of supernatural shudders because we were quite unable to understand it. Until this morning epilepsy was the divine disease, quite unsatisfactorily explained by a mishmash of ideas involving possession by evil spirits, prophetic gifts and superhuman strength. Is it then so strange that many of our fellow citizens react with apprehension and anxiety when mentally ill people say unpredictable things, behave in erratic ways, are subject to inexplicable impulses, and make startling demands upon us which we often cannot understand and which appear to have no order about them whatsoever?

In the course of his correspondence with Ralph Waldo Emerson, Henry James, Sr., once wrote: "I am led, quite without any conscious willfulness either, to seek the *laws* of these appearances that swim round us

in God's great museum—to get hold of some central *facts* which may make all other facts properly circumferential, and *orderly*."

The bogeyman who lives in the attic above junior's bedroom is not exorcised by patient explanation and sweet reason. He is routed by father's reassuring presence and by switching on a great many 100-watt light bulbs. Of course, he moves to some other dark and mysterious abode, the hayloft perhaps, or the root cellar, but this is quite another matter. While the lights are on and while father's arm is around junior's shoulder there are no mumbling phantoms crouched on the broken furniture or shuffling among the attic trunks.

The hospital volunteer and the new employee have a similar experience, I would expect, when they enter their first psychiatric ward. It is the light of understanding and the reassurance of experience which soon dispel the imagined terror and in time allow the willing observer to see more and more of the mentally ill, not as unpredictable monsters, but as lonely, suffering and unhappy human beings.

Some mental health education would appear doomed to failure because its naive exhortations are entirely dissociated from audience experience. It is, I think, akin in its ineffectiveness to a parent's insistence at the dinner table that there are no bogeymen in the attic. Junior simply asks for another dish of ice cream and keeps his own counsel with respect to goblins and their place of residence. Other educative efforts may be less than successful in spite of their unquestioned truth and logical coherence only because they are too fine-spun, too recondite. Their message has yet to be persuasively translated into language that the rest of us can lay hold of, into understanding that we can make our own.

If, as I believe, Henry James, Sr., was expressing a universal human need when he cried out to Emerson for an understandable order in God's great museum, then we whose vocations and interests are in the field of mental health may take comfort in our own insight into what remains about us of social prejudice, public apathy and legislative indifference. With a better understanding of the origin of these attitudes, and of the purposes they serve, we can reflect on the value of our dinner table exhortations about bogeymen, and wisely seek for ever better systems of illumination to push back the darkness.

DANA L. FARNSWORTH, M.D.

Social and emotional development of students in college and university

Part 1

Attention is being focused today on the college student as never before in American history. Education, science, business and industry, and government services all compete with one another and with other groups for his services. The man or woman without a college degree finds himself at a great disadvantage when it comes to bettering himself in our society. College administrators are staggered by the thought of what they must do to meet anticipated demands of a double teaching load in the next fifteen years.

In times of urgent attention to the demands of millions of students, to raising money and to constructing classrooms and laboratories, concern with the individual student should not be neglected. Indeed the success of all higher education depends in large measure on how each young man or woman feels about his college experience. It makes an immense difference whether he acquires attitudes and habits favorable to his own later intellectual, social and emotional development as a result of his college experience, or develops anti-intellectual tendencies accompanied by bitterness and frustration.

As our society has become more and more complex the number of choices the student must make becomes greater and greater. As we grow more mobile, more rootless, more urbanized and more dependent upon a web of interdependent technical devices the individual may feel that he has lost much of his significance. As a result he may become an easy prey for those who would exploit him.

Today's student is both fortunate and un-

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fortunate. Never in all history has he had so much to learn nor so many channels through which he may acquire information. Yet in the major disciplines and professions it is no longer possible to master the factual material. The student can learn how to think effectively with only the material in his area of interest. After he has acquired the basic tools of thought he can then, with appropriate judgment, balance his factual knowledge against his awareness of what he does not know.

This latter ability is more difficult to gain than mastery of factual material alone. It involves the weighing of various alternatives, and a knowledge of himself and the people with whom he is associated, and also the making of choices even when the facts are insufficient for certainty. In short, what we call social and emotional maturity is as desirable as is the development of intellectual power as an end product of formal education. Consideration of the emotions, of feeling, of unconscious determinants of behavior, and of those principles which affect interpersonal relationships are usually accorded only superficial consideration in the educational process. They deserve and require far greater attention.

SHOULD EDUCATIONAL GOALS BE BROADENED?

College students are the group from which the great majority of our future leaders will come. It is during their years at college that ideals and identity are largely established and that goals for the future are set up or redefined. Students are more inclined to formulate their ideals and to define their goals on the basis of what they see going on around them than in terms of some theoretically desirable system. What they observe will depend greatly on the attitudes of their teachers and especially on the attitudes of their own contemporaries.

At present there are no clear-cut methods that a college may adopt if it attempts the task of broadening the base of its educational goals to include an understanding of the emotions. Furthermore, there is no general agreement among psychiatrists and psychologists as to how to set up a program designed to increase understanding of personality factors, both of one's self and of others. Some institutions approach the task through the medium of courses in human relations, others through special counseling programs, and still others by way of psychiatric services associated with student health programs.

The crucial element in any educational institution determining the quality of feeling or sensitivity of its students, and their value systems as well, is the attitude of the faculty members toward their students. If teachers and administrative officers convey attitudes of friendliness, warmth and insistence on basic integrity and high intellectual standards to their students the quality of each individual's experience in college is quite different from that of the student who feels that his instructors are aloof, impatient of him and interested only in their subject and private affairs. Contact between students and their elder colleagues as they struggle with attainment of common goals forms the only effective way by which attitudes may be transmitted. There is profound truth in the cliché that attitudes are caught rather than taught.

At this point the complications mount. The demands made upon faculty members are constantly increasing, in part because of the extending borders of all fields of knowledge, greater numbers of students and economic pressures. A teacher who makes a good impression on his students may soon be swamped with personal interviews with them. Being friendly, helpful and willing to listen to their quandaries may result in

undue fatigue and interference with his own professional development. Yet a defense consisting of aloof attitudes, veiled contempt for undergraduates, preoccupation with research, and strained procedures to make himself inaccessible satisfies neither the teacher nor the students. The improvement of the quality of relations between faculty members and students is therefore a more reasonable goal than merely having them spend more time together. The students also have great demands on their time.

In their attempt to develop careful habits of thought and to instill a sense of responsibility and good judgment members of a college faculty are confronted with a vast number of influences that work against them. In our society materialistic notions or standards of success are everywhere emphasized. The man of action is rewarded both in terms of public esteem and in the size of his income. The thinker is often derided. He is the butt of jokes and cartoons and gets, on the whole, little public respect. Originality in thought is misunderstood or misinterpreted, sometimes deliberately. Our mass media of communication overemphasize stimulation, excitement and exploitation of the people, who are as often as not captive audiences—either in fact or by a process of seduction.

College students as they come through adolescence and approach maturity show the end results of the ideals derived from their families and from the church, school and society to which they belong. At the same time they are now in a position to examine those ideals more objectively and to decide whether they are suitable ones to pass on to their own children. This process will occur in a productive fashion only if the college realizes its responsibility in the matter and deliberately tries to organize its educational program toward the development of adequate values and attitudes favorable for satisfying and constructive living. If the educational philosophy of the college is based solely on the idea that its function is confined to the transmission and accumulation of knowledge, the formation of ideals and the development of a mature sense of responsibility will be accidental and more incomplete—far more than it need be.

If, on the other hand, a college or university accepts the responsibility of enlarging the scope of education to include the development of self-knowledge and a sense of responsibility, many new procedures will be needed and many attitudes will, of necessity, have to be changed. Instead of assuming that the student has developed responsible and mature attitudes if he has passed his work and has kept out of trouble, positive knowledge of the individual will be needed which can be obtained only by more personal contact between him and faculty members. Counseling will then become a stimulus toward integrity of intellect and character as well as an aid to problem-solving and a vehicle for giving information about courses and careers. The idea of such shifts of emphasis in higher education might be distasteful or alien to those who hold the cloistered study as their sole ideal of the academic life, for to them it would mean a painful re-examination of their own ideals and goals and how they relate to students and teaching.

Just as the knowledge of most teachers about the emotional reactions in their students is somewhat limited, so the knowledge of psychiatrists and their colleagues in related fields about education is far from complete. Psychiatrists are not qualified to come into any educational institution and tell educators what they should do. The most valuable contribution they can make is to work with teachers, deans, counselors,

student leaders and any others who are involved in interpersonal relations on problems in which one or more persons are angry, hurt, rebelling excessively, frustrated, feeling rejected or not working effectively. Every time a psychiatrist and an educator work on a common problem each learns from the other, and attitudes are altered in subsequent situations.

BACKGROUND FACTORS IN EMOTIONAL ILLNESS

As the college psychiatrist works with students who have emotional disturbances he is constantly impressed with how many of them originated in the student's earlier life rather than in conditions existing in the college itself. These unfavorable conditions of early life are by no means always inevitable, nor are they mysterious. They can often be modified. They are usually the result of defects of knowledge or character, or both, in the persons with whom the child had his closest personal contact.

Among these unfavorable conditions are included parental discord or conflict, emotional rigidity, intolerance and prejudice in parents and in older associates, lack of emotional warmth in parents and teachers, absent or inconsistent discipline (especially when friendly attitudes are wanting), improper or inadequate education about body functions, and other unfavorable environmental influences. There are, of course, many others, but most of them are derived at least in part from the general ones just enumerated.

THE STUDENT'S REACTIONS TO EXCESSIVE CONFLICT

The student concerned with conflicting emotions has a variety of ways of expressing his mixed feelings. Some of these are conscious and their significance is obvious, if not to him, at least to his friends; but a larger number are not conscious and hence his behavior may not make sense, either to himself or to others. The college junior who suddenly starts making poor grades after two years on the dean's list hasn't "suddenly become dumb," nor is it usually accurate to say that he is lazy. Another student may become apathetic and complain that he cannot make himself want to work. He has dozens of ways of postponing or avoiding work. He plays solitaire, goes to the movies, sharpens pencils, puts his room in order, visits his friends down the hall, plays some records—and still when he starts to study his mind won't do his bidding and focus its attention on the subject assigned. Sometimes he is concerned about the fact that he doesn't care and feels that he never was any good anyway and never will be. At other times he doesn't seem to care about his own lack of concern for his ineffectiveness. He has plenty of intelligence, but it is not at his disposal.

Sometimes a student will shift his worries without being aware of the process in such a way that a physical symptom takes the place of the original problem. Then he and his family can be concerned over the headache, the butterflies in his stomach, the easy fatigability, the fainting episode, or the frequent colds. The baffling thing about physical symptoms is that they may be caused by emotional conflicts or they may have no connection with the emotions at all and be due to an infection or to some other process which has affected some portion or all of the body. To distinguish between the two is not only difficult but at times well-nigh impossible.

An occasional student shows his inability to deal with his personal and private thoughts by escaping into overactivity. He goes out for many organizations and, after committing himself to far too many proj-

ects, overworks himself trying to live up to what is expected of him.

Another may withdraw from all extracurricular activities or express himself in words or behavior that his friends cannot understand and that do not make sense either to himself or others.

Those who act out their feelings are the most difficult to understand or to tolerate on a college campus. Their attitudes of hostility or aggressiveness, originally generated by something which happened at home or with close associates years before, become displaced onto something or someone in the college environment. They act in such a way as to provoke others to dislike them, they destroy property, they use alcohol quite inappropriately, they criticize others, and in general they manage to lose most of their friends, actual or potential. Yet this friendship may be the thing they most want and need!

Still other students get involved in a series of accidents or mishaps which seem at first glance unavoidable but which on closer inspection are found to be based on hasty and poorly conceived plans of action.

Psychotic breaks, including suicides, occur in colleges with disquieting frequency. A general estimate based on unreported experiences of various college psychiatrists suggests that about two psychoses can be expected yearly for each 1,000 students and that a suicide can be expected somewhat more often than once yearly in a student body of 10,000.

There are many other ways by which a young man or woman in college may show that he is in trouble, but these are enough to indicate that most of them can be recognized and the more important causes can be established.

These background causes are the really important considerations and they are usually involved with the kind of family from which the student came. In fact, these are so important that it seems to me—and to many of my colleagues who are primarily interested in the development of healthy personalities—that every college student ought to learn sometime in his college course what a good family means to a developing child. If knowing were sufficient, this particular educational device could easily be carried out universally. Unfortunately, learning how to get along with others, particularly with other members of one's own family, comes more from good examples than from precepts.

The college student whose parents have loved him sincerely and frankly, who have taught him wholesome attitudes about body functions, who have retained their ability to see how things look to him, and who have maintained a consistent discipline to which they themselves also adhered rarely gets into serious or long continued trouble. If, in addition, they have encouraged his gradual independence from them by respecting his decisions, have furnished as good home surroundings as possible, and have been patient with him as he worked through his appropriate stages of childhood, his chances of an effective and satisfying college life are still further increased. Such a person is likely to have an affectionate nature with the capacity both to give and to receive affection. He can put up with considerable frustration and an occasional defeat. He can think of others as well as himself and respect them because they are human beings.

Not all students are so fortunate as this ideal one I have just been describing. The student who is struggling with an emotional handicap needs the understanding of his teachers and friends while he is in the process of trying to understand himself. This world has many paradoxes, not the

least of which is why we as people are so afraid of coming to grips with the problem of understanding ourselves. In this respect it is encouraging to observe that resistance of this sort usually comes from people of my generation, not from those of high school or college age. The student approaching college has, as a general rule, an open mind about a number of matters concerning personal development and emotional stability which his elders view with anxiety.

RELATIONSHIP BETWEEN STUDENT AND COLLEGE

What can a new student do in college that will be of the greatest aid in satisfying accomplishment? How should he think about himself and others? How can he avoid overreacting to events in his own background which may have been unfortunate? How can he avoid becoming so busy that he hasn't time to live?

Colleges are not organized—or at least *should* not be—to fit their students into some type of preconceived mold or stereotyped intellectual and cultural pattern. A student's experience begins with what he brings with him in the way of attitudes, motivation, conditioning and point of view. The college does the best job, in my opinion, when its officials and teachers see it as their function to respect the individuality of each student, recognize his differences, encourage his peculiar strengths and attributes, and give him the maximum opportunity to grow. As Karen Horney has said, you cannot teach an acorn to become an oak tree. At the same time, as these attitudes are being expressed in their direct and indirect teaching, the necessary compromises in group living are being considered in many different ways, so that order may be achieved but not at the expense of conformity, which in itself would not be conducive to intellectual and spiritual progress.

In this the student himself can help immeasurably by paying some attention to understanding himself. A student should think of college, not only in terms of what it can give him, but also of what opportunities will be his in the way of stimulating and friendly associates, library facilities, athletic and social activities, and possibilities of serving others. Instead of thinking of education as the accumulation of facts and skills, he will think of it as the acquisition and encouragement of curiosity and of that sense of wonder which makes for humility, and as the development of a lifelong attitude of respect for the search for knowledge and truth.

He will not let the few things that are wrong with his college get in the way of using and appreciating those things that are right about it. He will not think of college as preparation for life, but as life itself, the time and place when the tone and standards are set, the social organization in which there is just enough protection to keep him from being overwhelmed and defeated by his own mistakes but not enough to keep him from making his own decisions, good or bad, and seeing and facing their consequences. Undesirable traits or attitudes resulting from unfortunate early experiences can be modified while the desirable ones are strengthened, assuming that the majority of the college faculty and upperclassmen have a dynamic concept of personality growth and a real liking and respect for human beings generally. This is admittedly a large assumption.

A SIGNIFICANT CASE HISTORY

The experience of a recent student patient illustrates the need for widespread awareness of what may affect the develop-

ing personality of a growing child. This student went to his college chaplain stating that he was having scholastic difficulties. The chaplain recognized immediately that his problem was a serious one and that it was emotional in origin and referred him to the college psychiatrist.

When he came to the psychiatrist's office, he was obviously very tense and talked rapidly about many things in his background. He had been to many different schools and said that every time he was "dumped into a new group" his troubles became more numerous and varied. He had a mild stomach-ache every night when he went to bed.

In his childhood he had feared the dark until he was 15 years old. Because of this, he was frequently allowed into his parents' bedroom where he was made aware of their varied sexual activities. He worried over his own erotic feelings. He became very confused about his religious beliefs. His parents quarreled a great deal, and at various times were on the verge of divorce. Any display of emotion on his part was frowned upon. His mother was indecisive and inconsistent. He gradually learned that if he could get his father and mother into an argument he could get his own way. He then hated himself for his selfishness.

He was sent to a physician who gave him a physical examination. As a result of a basal metabolism test, the physician reported that he was "deficient in energy," to which the patient commented, "Of course, I didn't have enough energy. I was too filled with conflict."

Brief psychotherapy helped him finish the college year with satisfactory grades, but he would not consider intensive treatment. In his next college year he refused treatment altogether, finally withdrew from school, became psychotic two months later, and then spent several weeks in a mental hospital.

At the time of his psychotic break his parents finally began to appreciate some of the causal factors that had led to his illness. Of these his father wrote, "The whole condition must be due to the emotional adjustment between my wife and myself during his infancy and early childhood. These conflicts, although under some control, did go on, and must have taken their toll on his sensitive and formative mind. There is certainly great lack of understanding in this groping world in which we find ourselves, and there is much constructive work yet to be done. It is indeed a pity that the youth of the land should have to suffer in such a real and agonizing fashion for the blindness of their elders, but it is indeed very difficult for a sincere person to find out or to know the right answers."

THE BASIC PROBLEM

This case, reported in barest outline, is typical of many thousands of students in our colleges although perhaps more severe than some insofar as this student had to be hospitalized. The tragedy is great no matter where or when such a situation occurs. It is prevalent among people who are intelligent, well-educated by formal standards, religious in intent and belief, and among those persons who occupy positions of great responsibility and influence. Indeed, the number of persons influential in the professions, in business and in government who exhibit regrettable emotional immaturity and lack of even elementary knowledge of the needs of young developing personalities is very great.

The point at issue is whether or not it is possible to develop the necessary knowledge and insight in large numbers of our people in order that the antecedent causes of severe and incapacitating emotional illness

and social conflict be diminished at their point of origin. Knowledge alone is not enough. Acquiring insight into the nature of one's own reactions and relationships with others is a very complicated process. Individual psychotherapy may be helpful for the few but it is too expensive for the many.

Would it not be an interesting experiment if at least a few of our influential institutions of higher learning made a serious effort to find out whether new educational procedures could be devised, or present ones modified, to permit larger numbers of our students to acquire true maturity in more areas, not simply intellectual power?

EXPERIENCES OF COLLEGE PSYCHIATRISTS

Another aspect of the scope and urgency of this problem is revealed by an analysis of the experiences of college psychiatrists during the last four decades.

The earliest practical demonstration of the need and desire of college students for some kind of professional attention directed toward personal problems was that of Dr. Stewart Paton at Princeton in the few years following 1910. He indicated that he was available for consultation regarding matters of a personal nature, and the Princeton students "flocked to him by the dozen." [1] In the next few years Blanton at Wisconsin,[2] Menninger at Washburn,[3] Kerns at West Point,[4] Ruggles at Dartmouth and Yale [5] and Riggs and Terhune [6] at Vassar discovered that students, because of their emotional turmoil, showed great interest in mental health.

In the intervening years progress in the development of college mental health programs has been steady but slow. The largest departments are located at the Universities of California, Wisconsin and Minnesota, Yale, Harvard and M.I.T. At least one full-time psychiatrist is on the staff of the student health services at Vassar College, Cornell, Columbia and Pennsylvania State Universities, and at the Universities of Nebraska, Massachusetts, Colorado, Pennsylvania, Indiana and Chicago.

NUMBER OF COLLEGE PSYCHIATRISTS

A reasonably accurate estimate of the number of full-time college psychiatrists is about 38 to 40. Two recent surveys indicate that slightly more than 100 colleges have a mental hygiene program with at least the services of a part-time psychiatrist. In many of these colleges the service can care for acute emergencies only.

FINANCIAL SUPPORT

Two institutions, Yale and Vassar, have endowments for the maintenance of a mental health program, each with $2,000,000. The same donor provided both. Yale has elected to develop a combined program of training, treatment and research. Vassar has emphasized research particularly, and a recent report gives a good idea of its range and scope.[7] The other colleges and

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[1] W. Richmond, "Mental Hygiene in the College," *Journal of the American Medical Association*, 93 (December 21, 1929), 1936–39.

[2] *Who's Who in America*. Chicago, A. N. Marquis, 27(1952–53), 226.

[3] *Washburn College Catalogue*, 1920–1921. Topeka, Washburn College, 1920.

[4] H. N. Kerns, "Cadet Problems," *Mental Hygiene*, 7(October 1923), 688–96.

[5] A. H. Ruggles, "College Mental Hygiene Problems," *Mental Hygiene*, 9(April 1925), 261–72.

[6] A. F. Riggs and W. B. Terhune, "Mental Health of College Women," *Mental Hygiene*, 12(July 1928), 559–68.

[7] Nevitt Sanford, "Personality Development During the College Years," *Journal of Social Issues*, 12(4, 1956), 1–70.

universities are usually dependent on a small portion of health fees paid by students. Very few colleges consider that mental health has anything to do with education if one judges by the prevalent lack of support.

GOALS OF COLLEGE PSYCHIATRISTS

For nearly ten years a group of psychiatrists working with college students has been meeting regularly twice each year as one of the regular committees of the Group for the Advancement of Psychiatry. The original name of the committee was the Committee on Academic Education, later changed to the Committee on the College Student. Although the membership changes gradually, the theme continues constant—namely, what procedures, devices, methods or techniques will be helpful in promoting better teaching and learning in our colleges and at the same time contribute to greater emotional maturity of both students and faculty. Two reports have been issued, *The Role of Psychiatrists in Colleges and Universities,* in 1950 and *Considerations on Personality Development in College Students,* in 1955. In both of these reports there is an obvious effort by the compilers to go beyond the treatment of disturbed students and to utilize the ideas and principles derived from the study of students under stress in the development of more effective teaching methods and in the improvement of relationships between students and faculty. Thus it is hoped that the psychiatrist can be of service to all students, not just those with acute emotional disturbances.

EXTENT OF STUDENT NEED

Practically all psychiatrists who have had extensive experience in working with college students agree that a very considerable number of students in any college are likely to need help each year because of emotional problems which interfere seriously with their work. A common estimate of the number is 10% of all students. Very few institutions have psychiatric services extensive enough to see this number of students. In fact, the upper limit of psychiatric consultations and therapeutic interviews in colleges and universities at the present time is determined, not by need, but by number of hours of psychiatric time available. Thus the lack of financial and professional resources have so far prevented any definitive demonstration of the full extent of emotional illness in any student body. An unofficial survey by one psychiatrist of the amount of private psychiatric care given to students in an eastern professional school revealed that an average of five hours of psychotherapy for each student enrolled had been given the previous year (1954–55). This is far in excess of the amount of help given students by any regularly organized college psychiatric service. It does lend support to the opinion held by many college psychiatrists, particularly those who work in universities with several graduate schools, that numerous students in many of our professional schools have serious and unresolved emotional problems that greatly impede their professional development.

Psychiatrists who work in colleges are constantly under pressure to treat intensively those students who are faced with some conflict which is sufficiently severe to interfere with effective academic performance. But to yield to such pressure may mean to lose the opportunity of bringing principles derived from psychiatry to bear on the development of those students who are not apparently in trouble but who are at the same time not using their abilities

to the optimum extent. As a compromise, most psychiatrists attempt to aid in the resolution of crises, engage in brief psychotherapy for those whose outlook for mental health appears to be hopeful, and refer patients in need of definitive treatment to outside facilities. In many instances this means no help can be obtained because of insufficient clinical or financial resources.

It is important for the psychiatrist to explain to his academic colleague the nature of stress and the variety of reactions to it—both healthy and unhealthy—that students exhibit. Such knowledge should help the teacher. Formulas and rules do not work. The more the general principles are reduced to rigid rules, the less likely they are to be useful. The real secret of success is the presence of well-trained persons of keen intellect who are aware of the complex issues that are involved, and who will work with student leaders and with members of the faculty and administration as they deal with problems of students and others. This is one of the chief arguments for the establishment of training centers for young psychiatrists who are attracted to careers in college psychiatry.

OBTAINING QUALIFIED PERSONNEL

Such a plan comes in for discouragement from various sources. Some college officials believe the presence of a psychiatrist will attract unstable students. College administrators are frequently not aware of the factors involved in attracting and keeping good young men and women in this field. Often the financial resources are not available. President Blanding of Vassar has said that support for mental health activities in a college is no more difficult to get than other college activity providing the governing boards consider them desirable.

No college can hope to retain a competent psychiatrist on its staff unless it is willing to pay him a salary to compete with what he might make in private practice. This need not be excessive in view of many secondary benefits to be derived from membership on a college faculty, but it should reflect the long period of training that he must have had. In practice this means that the administration should know that the duties of a college psychiatrist are frequently much more taxing than those of his academic colleagues. He is responsible for life-and-death decisions. His hours are irregular. Emergencies occur frequently and often require full-time concentration for considerable periods. He is frequently the recipient of much hostility in connection with his duties, sometimes to the point of physical violence.

Many educational institutions, particularly those supported by the states, do not permit a psychiatrist on their staff to see private patients. The reasons for such a restrictive policy may be sound and logical, but in practice the result is that many positions are not filled. In the long run the personnel problem can be solved only by a composite program designed to attract good young men and women into the field by encouraging colleges and universities to support them properly and by establishing training centers. In the training programs, emphasis should be placed on devising procedures by which psychiatrists and other professional workers function as much as possible through members of the faculty and the administration rather than by treating more and more students individually as patients.

BERTRAM MANDELBROTE, B.Sc., M.B., M.R.C.P., D.P.M.

Development of a comprehensive psychiatric community service around the mental hospital

In Britain today the isolation of the mental hospital is rapidly disappearing; this was practically absolute before the Mental Treatment Act of 1930 when, for the first time, patients were able to enter hospital as voluntary patients. The emphasis is being placed more and more on the provision of an over-all psychiatric service for the community. This enables the early treatment of psychiatric problems, the assessment of the problem relative to the family unit (with the treatment of the family unit if this becomes necessary) and the management of psychiatric problems within the community. The function of the mental hospital would then be mainly as a centre for the treatment of difficult psychiatric problems not manageable within the community for social or other reasons.

The first trend towards management of psychiatric problems in the community started with the development of out-patient centres, and has proceeded further with the opening of day hospitals and night centres. At the same time training in the early recognition of mental health problems is being extended to general practitioners and public health officers who, in conjunction with psychiatric social workers, can then meet the needs of the demands more effectively. The emphasis is now toward the supplying of an over-all service for the community which would entail the education of the community toward recognition and tolerance of mental illness, and the early referral of psychiatric problems through the proper training of general practitioners and health visitors.

Dr. Mandelbrote is physician superintendent and consultant psychiatrist at Coney Hill and Horton Road Hospitals, Gloucester, England. His paper, "An Experiment in the Rapid Conversion of a Closed Mental Hospital into an Open-Door Hospital," which appeared in the January 1958 number of MENTAL HYGIENE, has attracted wide attention in the U. S.

The use of a domiciliary visiting scheme provides an opportunity for the psychiatric team to assess the extent of the problem and the type of management which would enable the quickest return to normal functioning. In Amsterdam a scheme for domiciliary visiting and community care has been run by the authorities for 25 years and has proved efficacious. Dr. Querido estimated that approximately 3,000 psychiatric patients are maintained and followed up within the community. However, the Amsterdam scheme, whilst highly admirable, does not provide for a truly comprehensive service because it leaves out the mental hospital.

In Britain in some of the provincial areas, especially Nottingham and Gloucester, the community psychiatric service is provided by the psychiatrists from the hospital, with the mental hospital as the centre pivot in the service. The whole question of prevention of institutionalisation and early rehabilitation can then be combined with the over-all programme of treating psychiatric problems within the community. Admission to a mental hospital would be for specific treatment or for special social reasons where treatment cannot be carried out readily in the home, or in day centres or out-patient clinics.

In these areas as a result of the education of the general public and the co-operation of the local authorities, it has been possible to train mental health workers in such a way that they are able to participate in the follow-up and rehabilitation of psychiatric problems, in close liaison with the management of these patients by the psychiatrists from the mental hospital. This scheme also provides facilities for the follow-up of all discharges from the hospital and the review of these discharges at intervals. Many problems are managed in the out-patient clinics and day centre. Decisions relating to the admission of problems to the hospital are made following consultation either in the out-patient clinic or following domiciliary visiting by the psychiatrist or the psychiatric social worker or mental health officer.

For the mental hospital to play its role effectively it is very important to remove the barriers isolating the hospital from the community and to provide an internal psychotherapeutic atmosphere within the hospital, which in turn will have the function of further enlightening an informed public opinion in the community. To obtain this sort of atmosphere is not possible within the framework of custodial care and a locked door system. Another major barrier is certification. Many critics of these alterations in mental hospital management maintain that these procedures cannot be avoided without embarrassing the hospital and presenting a hazard to the community and difficulties in getting patients to come for treatment.

This has not been my experience; within the last three years it has been possible over a period of six months to facilitate the opening of the doors of the hospital [1] and a 30 months follow-up shows that the difficulties encountered have been extraordinarily few, although not completely without mishap (see Table 1).

An interesting experiment was carried out over a 12-month period in which certification was avoided by the use of temporary admission under a section order (a short-term order extending from 3 to 28 days) usually carried out by the mental welfare officer on the advice of a psychiatrist without the presence of a magistrate. This order is described as an observation order and

[1] B. M. Mandelbrote, "An Experiment in the Rapid Conversion of a Closed Mental Hospital into an Open-door Hospital," *Mental Hygiene*, 42(January 1958), 3.

TABLE 1

Difficulties encountered in an unlocked hospital

	6 MONTHS PRIOR TO OPENING DOORS	6 MONTHS AFTER OPENING DOORS	12 MONTHS AFTER OPENING DOORS	18 MONTHS AFTER OPENING DOORS	24 MONTHS AFTER OPENING DOORS	30 MONTHS AFTER OPENING DOORS
Absconders *	28	29	57	33	48	24
Destructive and impulsive patients	(Av.) 123	30	30	23	5	4
Seclusion	236	40	10	16	3	–
Bed patients	(Av.) 100	20	20	20	19	8
Incontinent patients	120	45	31	28	22	16
Fractures	13	8	6	10	9	16

* Frequent absconders were retained in closed groups. These closed groups included 5 male patients (2 chronic wanderers and 3 difficult young schizophrenics) and 5 female patients, all chronic wanders.

The casualties included 1 deteriorated schizophrenic who wandered off, was lost and was later found dead, 1 woman victim of obsessional depression who committed suicide by throwing herself into the river (she had been treated with 9 ECT's) and 2 patients who absconded and whose whereabouts are not known.

TABLE 2

Outcome of 200 patients under observation July 1956 to June 1957

JULY 1957		31ST DECEMBER 1957		REVIEW 31ST JULY 1958	
		Discharged	123	Out of hospital	134
		Deaths	8		
Becoming voluntary	160	Re-admitted	5		
		Continued in hospital	24	In hospital	33
		Out of hospital	13	Voluntary 29	
		Re-admitted	10	Certified 4	
		Becoming voluntary	7		
Discharges on expiration of order	23	Deaths	1	Transfer to other hospitals	1
		Discharges	2		
		Including 1 transfer to an other hospital			
Deaths	17			Deaths	32

Of the 9 discharges on expiration of order not re-admitted, 2 are in welfare homes and 7 in the community (5 of whom are known to be improved).

is for the patient frequently not very different from the ordinary type of admission that the individual encounters going into a general hospital.

As a result of diligent application of this section it was found that out of 760 patients admitted during the year from June 1956 to June 1957 it was necessary to admit 200 patients under an order of this nature in order to prevent compulsory detention (see Table 2).

The outcome of these patients is very interesting; in the vast majority of cases, as a result of early treatment and classification and the atmosphere within the hospital, 84% of them remained as voluntary patients and completed their treatment with satisfactory result. In only 14 instances were second admissions on an observation order necessary over the next 12 months and in only 4 instances were these orders repeated. Following up these patients a year later shows that only 4 of these patients required eventually to be certified, and in each of these 4 cases attitudes have changed in such a way, as a result of relationships made with doctors and others, that the patients would be willing to continue to co-operate and they will probably be regraded as voluntary patients.

The extent to which patients can co-operate within a homogeneous and therapeutic atmosphere within the hospital is also an interesting question. In this particular hospital three years previously out of a total of 1,529 patients 1,045 were certified patients. By the simple process of regrading patients who seemed suitable as voluntary patients—namely, those who would not leave the hospital against advice —it has been possible to reduce this number to a mere 19 over a 3-year period and I have little doubt the number could be further reduced until there were virtually no certified patients at all (see Table 3).

Achievement of co-operation and willingness for treatment depends to a large extent on the atmosphere and morale within the hospital. Interpersonal relationships which take place inside the hospital play an important part, together with encouragement of patient participation in responsibility, thus enabling them to find a place for the use of their assets and talents.

In addition to the essential preliminary methods of opening doors and removing certification, the problem of overcrowding has to be dealt with so that the patient can receive adequate individual treatment. This problem can be tackled only within the framework of community treatment which facilitates the use of the mental hospital for active treatment, and the early rehabilita-

TABLE 3

Patients remaining on the hospital register

	1958	1957	1956	1955	1954
Voluntary	1,173	1,082	684	473	479
Temporary	–	–	2	4	5
Certified	19	210	681	944	1,045
Total	1,192*	1,292	1,367	1,421	1,529

* 1,134 (May 1959).

tion of problems that can be managed within the community with psychiatric supervision. It is facilitated by stringent attempts to prevent institutionalisation, which is rampant throughout the mental hospital, and by encouraging patients' participation in responsibility and management in contrast to the dependent attitudes produced in the past. Facilities for adequate occupational therapy, social and recreational functions, and rehabilitation designed toward fitting the patient for the community are necessary. Temporary return to the community is encouraged through maintaining contact with relatives. Frequent visiting, weekends at home and longer periods of leave are arranged as the patient improves, and in some instances gradual weaning is achieved through the use of a day unit or attendance at a day or night hostel.

Community tolerance of minor forms of aberrant behaviour or handicapped functioning is required, and is very much dependent on community education and the relationships that the community have with the mental hospital. Until the patients begin to speak highly of their management and treatment within the hospital, one cannot expect the public to look with enthusiasm and favour on psychiatric treatment and management within the mental hospital.

In order to alter public attitudes favourably towards early treatment, decoration and modern amenities are necessary in at least a few of the wards, with the eventual aim that the mental hospital should provide sufficient of an aesthetic atmosphere to prevent the patients or their relatives developing the feeling of being put in surroundings where nobody really cares.

Once the viewpoints of the patient, the atmosphere of the hospitals and the attitude of the community have tended toward adjustment then each reacts beneficially on the other. In Gloucester, following the formation of a League of Friends and the encouragement of visitors into the hospital, members of the public have begun to participate in hospital functions to the extent of providing leaders for gardening clubs, camera clubs, art classes, domestic science classes, French classes and singing classes; the Women's Institutes have become a focus for re-introduction of small groups of long-stay patients into the community. This has been followed by the purchase of a hospital bus which enables 15 patients to enjoy a daily outing to local Women's Institutes or British Legion Clubs, and the entertainment has become mutual in that the Women's Institutes have repeatedly invited the same groups of patients who visited them before. The entertainment consists of entertainment to tea, organisation of games such as musical chairs or darts and skittles for the men, and in some instances have had considerable educational value in that patients have been invited to interesting homes and learnt something about furnishings and gardens and the local history of the community centre that they are visiting. This contact begins to extend further as the prestige of the hospital treatment increases and can provide an effective liaison with employment exchanges, local employers and other agencies in the community whose help the patients are likely to need.

The extent to which home visits play a part can be indicated by the following figures (see Tables 4 and 5).

Throughout 1957, 288 patients were visited in their homes by a psychiatrist and a considerably larger number by mental health workers and psychiatric social workers. Of these 288 approximately 50% required to be admitted to hospital. One year's follow-up showed that in only five

TABLE 4

Domiciliary visits, 30th June 1956 to 1st July 1957

NUMBER OF VISITS	MANAGED OUTSIDE OF HOSPITAL	ADMISSIONS TO HOSPITAL			OUTCOME OF PATIENTS ADMITTED TO HOSPITAL		
		Voluntary	*Section*		*Discharges*	*Deaths*	*Still in Hospital*
			20	21			
288	132	125	11	20	144	7	5

instances were patients still in hospital, emphasising the extent to which close contact with relations and early recognition of the patient's illness can facilitate improvement and simplify the over-all management and care of the patient.

A very large number of chronic problems that are sifted to the mental hospital, especially in Britain, fall into the category of social or geriatric problems. These are in addition to the hard core of chronic psychiatric problems in the mental hospital, to some extent perpetuated by long periods of custodial care. Without proper screening and a community service for classification and management of geriatric problems within the community, rapid overcrowding of mental hospitals would very readily once again occur—thus defeating attempts to provide a therapeutic atmosphere within the hospitals, which is so vital to the morale of the patient and which so much affects the judgement of the mental hospital by the community as a whole.

Quite apart from the correct classification and screening of geriatric and social problems there are two major categories of chronic psychiatric problems which can be managed far more adequately in the community with psychiatric supervision than is supposed. These two categories include chronic schizophrenia, especially chronic paranoid states allied to schizophrenia, and psychosis in the senium, especially senile paranoid psychosis and mild forms of senile dementia.

It has been found possible to manage a number of these schizophrenic states comparatively well with adequate psychiatric supervision, especially now that tranquilising drugs deal so effectively with disturbed

TABLE 5

288 cases seen on domiciliary visits

CATEGORIES		TOTAL
Psychosis		128
Schizophrenia	38	
Paranoid states	27	
Manic states	6	
Endogenous depression	53	
Epilepsy	2	
Alcohol	1	
Mental defective	1	
Dementia		46
Senile	38	
Organic states	8	
Psychoneurosis		90
Anxiety states	24	
Anxiety with depression	42	
Anxiety hysteria	5	
Hysteria	18	
Obsessional neurosis	1	
Severe Personality Disorders		24

behaviour. In the case of senile problems the support of the family can be enlisted by facilitating temporary relief of the family by the taking of the patient for limited periods. In several hospitals geriatric patients have been admitted for 1-month periods during which time investigation and active treatment has been undertaken. The relatives then play their part in managing the problem, having previously agreed to accept the patient back after the month has elapsed. These patients will, of course, be re-admitted for further periods if the relatives find they cannot cope, but through the utilisation of welfare services (such as home helps and 'meals on wheels') and with local district nurse and mental health officer cover they are usually able to manage.

At Nottingham, for instance, it was found that twice the number of geriatric patients could be admitted without increasing the number of long-stay problems which blocked beds within the hospital.[2] Where the strain on relatives is temporarily too great, whether for physical or more commonly for psychiatric reasons, further responsibility for the patient can be undertaken by day hospital care or by providing a bed in a long-stay annexe.

The liaison and integration of the local welfare service and chronic sick service are of very great consequence, as all three of these services constantly overlap. With smooth arrangements for interchange, overcrowding can be prevented. Acute problems can be admitted without delay and managed efficiently, ultimately providing improved classification and ensuring that beds for acute patients are promptly available.

The extent to which chronic patients can be re-introduced into the community is very interestingly emphasised by the scheme of a half-way annexe which is being run in Gloucester (see Table 6).

These annexes were private houses of a modest nature—Victorian semi-detached houses with 5 or 6 bedrooms and 3 living rooms and a garden—situated in the centre of a mixed residential area in the town; they were purchased and converted as half-way houses. The sort of patient that was sent there was mainly a chronic type of patient deprived of family and community contact because of social isolation, who had had a long stay in the mental hospital and whose behaviour was not grossly disturbed behaviour.

In three such semi-detached houses 134 patients have been treated over the past 2½ years; of these patients 68 have been discharged into the community and only 15 had to be returned to the parent hospitals. Experience indicates that even this type of chronic problem (a cross section of the chronic mental hospital population—chronic schizophrenia, chronic depression, chronic personality deterioration, defectives with psychotic problems, geriatric problems and problems of severe hypochondriasis) was after many years in the mental hospital still a source for rehabilitation in the community.

One of the concerns in community psychiatry schemes is related to the welfare of the patients and the position of the patient within the community. It has been said that discharge without supervision is much worse than institutionalisation within the hospital. A follow-up of 703 discharges from Coney Hill Hospital in 1956–57 shows that in 73 instances the patients were readmitted to hospital and that 40 were still in hospital one year later. Of the remaining discharges one had committed suicide and 5 were managing badly at home. At least 505 were functioning in the community and the remainder were living in wel-

[2] D. Macmillan, "Community Treatment of Mental Illness," *Lancet*, 7039(July 26, 1958), 201.

TABLE 6

Admissions to and discharges from a half-way annex between January 1956 and July 1958, by diagnosis

ADMISSIONS			DISCHARGES		
Schizophrenia (including paraphrenia)		48	Schizophrenia		27
Senile states		43	Senile states		17
Paranoid	23		Paranoid	9	
Affective	13		Affective	5	
Dementia	5		Neurotic	1	
Neurosis	2		Dementias	2	
Affective states		12	Chronic neurosis		10
Mental defective (with psychosis or behaviour disturbances)		13	Affective states		10
Psychological invalidism (with chronic neurosis and/or hypochondriasis)		18	Defectives		4
Organic states		3	Total		68
Total		137	Discharged home *		44
			Discharged to welfare accommodation		24
			Total		68
			Re-admitted to hospital		15

* Of 68 discharged, 35 were managing satisfactorily at home or in jobs, 8 were re-admitted, 2 were managing doubtfully and 23 were managing satisfactorily in welfare homes.

Discharged patients' average stay in hospital was approximately 10 years (ranging from 2–35 years).

fare accommodation or had been transferred to other hospitals or had left the district (see Table 7).

Of these discharges 130 women were of child-bearing age (between the ages of 16 and 45); 9 became pregnant and there were 7 live births; 2 are pregnant for a second time. The only 2 illegitimate pregnancies resulted in an extra-marital miscarriage in a psychopathic patient and the termination of pregnancy in a young girl who had recovered from schizophrenia. Two patients were not traced in this follow-up. As the proportion of illegitimate births in the county is approximately 1 in 5, these figures do not differ markedly from the position in the community at large.

TABLE 7

Discharges from Coney Hill Hospital, 1956–57

Discharged to annexes	20
Discharged to welfare accommodation	18
Transferred to other hospitals	28
Left the area	55
Deaths (including 1 suicide)	13
Abscondings (whereabouts not known)	2
Patients not managing	5
Not satisfactorily traced	17
Managing satisfactorily in the community	505
Total	703 *

* 73 of the total were re-admitted and 40 are still in hospital.

The setting in which the patient has treatment is usually regarded as being subsidiary to the actual treatment itself. However, it is becoming apparent that the setting for treatment is also of therapeutic value, for unless it is possible for the patient to be treated without marked loss of self-respect and unless the doctor/patient relationship can be adequately preserved, difficulties arise which may adversely affect the extent to which the patient improves.

For example, a woman in her middle forties who was floridly disturbed with paranoid delusional ideas was recently referred. On a previous occasion she had been forcibly detained and certified, spending 15 months in a mental hospital before discharge. Initially she refused to be seen —associating the referral with the previous procedure that led to her certification. She agreed, however, that if an independent non-medical witness said she ought to come into a mental hospital she would come. Arrangements were made for admission under a short-term order for observation, and treatment was started. The patient, shortly after admission, attended the day centre and made good contact with the staff there. After four weeks of treatment with Largactil and contact with the therapeutic procedures present in the day centre, she was fit enough for discharge, having spent the previous two weekends at home with her husband. She went away on a holiday and was seen subsequently in the out-patient clinic, which she attended willingly. She had stopped taking her Largactil tablets and had made a good improvement and expressed her willingness to continue contact with the clinic, saying that now she had got to know us and knew she was not going to be removed by force, she was perfectly willing to come to us for assistance.

Deprivation of civil rights and restriction undermine self-confidence and aggravat emotional disturbances, destroying the vita personal relationships, mutual confidenc and trust which I think has an importan bearing on the management of patient especially psychotics. Even the chroni psychotics who do not necessarily lose thei delusional convictions can be managed an rehabilitated more readily when this pe sonal relationship exists.

An important aspect of any such proble is the extent to which the family and com munity relationships have been disturbed a a result of the patient's behaviour and th treatment of the patient. The outcome o the treatment will be very closely boun up with the attitudes of the family and th community. Once the family or the com munity close their ranks to the patient attempts to restore the patient in thei midst are strongly resisted and minor be haviour disturbances are not tolerate readily. By maintaining good contact wit the family and helping the patient an family with their differences and difficulties institutionalisation problems are lessened and rehabilitation is made easier. This i facilitated by schemes of domiciliary visit ing, keeping the family informed about the patient's problems and advising how diffi culties can be managed. In this way fami lies are encouraged to take patients out for short periods, weekends and longer periods at home when they begin to improve.

The mental hospital segregates patients into artificial groups and is really only suitable for short-term treatment and rehabilitation, but not for long-term treatment and social readjustment. Social readjustment is really in the sphere of the family and the community. If the family is not disrupted it is used to dealing with problems of this nature. When family attitudes can be canalised into therapeutic channels the family unit serves a very useful purpose in

assisting towards easier social adjustment, uncomplicated by awkward and aggressive attitudes which are built up more readily in a setting of compulsion and restriction. In the chronic psychotic, symptoms, although not eradicated, cease to be a major or dominating feature in the patient's existence in many instances—evidenced by the large number of chronic psychotic patients living in the family unit (half-way annexe accommodation) who have been discharged back into the community (see Table 6). The more flexible management of community treatment encourages the patient's natural tendency to social readjustment and helps him to remain in the community despite the handicap of chronic psychosis.

Development of a scheme of this nature also results in closer contact between the general practitioners and the psychiatrist, and interested general practitioners are being helped in the management of their patients as a whole. This close contact through domiciliary visiting is being extended with the holding of seminars in mental health clinics for general practitioners, thus encouraging them to refer patients early, and assisting them in the appreciation, understanding and even management of psychiatric problems. It not only makes possible the continuity of care for all forms of psychiatric illness, but it helps the patient and the public to accept the mental hospital and the mental health department in the sort of way that they accept the general hospital and other public health services.

SUMMARY

This paper deals with the development of a comprehensive psychiatric community service based on the mental hospital. It involves the setting up of out-patient clinics, day and night centres and a domiciliary service, the education of the community towards recognition and tolerance of mental illness and the training of family doctors and public health officers—in this way facilitating early referral of psychiatric problems and the continuity of management of these problems.

The mental hospital is seen primarily as a therapeutic community for the treatment of difficult psychiatric problems not manageable within the community for social or other reasons. The emphasis is laid on the extent to which many chronic psychiatric and geriatric patients could be managed within the community, with better facilities for continuity of care if the isolation of the patient from the community is prevented and the community learns to tolerate some eccentricities of behaviour.

MORRIS KLAPPER

Sample survey o admission of ex-mental patients in rehabilitation centers

In an effort to ascertain the extent to which leading rehabilitation centers are including ex-mental patients in their programs, an inquiry was sent to 86 such centers throughout the country in the fall of 1958. A total of 78 replies were received. The replies came from 28 states, representing 58 local communities in the United States and Canada. They indicated that 23 centers were currently serving ex-mental patients; 40 centers did not include such patients in their programs, and 15 centers were planning to have such patients included in the near future. Thus, out of 78 centers, 38, or almost half, either had programs or were planning programs for the ex-mental patient.

Of greater significance than the statistics is the actual range of programs supplied by those centers which were serving the ex-mental patients. The following excerpts, culled from correspondence and reports received from these centers, demonstrat graphically their successful experiences i serving the ex-mental patient.

Mr. Klapper is assistant executive director of the National Association for Mental Health.

REHABILITATION CENTERS WHICH ADMIT EX-MENTAL PATIENTS

ARIZONA

Samuel Gompers Memorial Rehabilitatio Center of the Maricopa County Society fo Crippled Children and Adults, Inc., Phoe nix: "At the present time we are making ou services available to a limited number o ex-mental patients who are referred to u by the State Division of Vocational Rehabil itation. These referrals are for our pre vocational evaluation unit. We utilize th "Tower" system of pre-vocational evalua tion and from all indication the neuro psychiatric individual fits quite well into this program. . . ."

CALIFORNIA

Herrick Memorial Hospital, Berkeley: "Our center at the present time is a small

one (16 staff members) with a caseload of a little over 1,000 patients per year. It is operated as a community project in a general hospital. We have no restrictions as to diagnosis, age, etc. The only criterion is self-care though it may only be a limited one. Primarily our mental patients have had actual physical problems either caused by suicidal attempts or disease or injury sustained prior to the mental illness. It should be pointed out that most of our mental patient referrals come from our hospital's 46-bed psychiatric unit. The patients are housed there and are admitted primarily for their psychiatric problem. Due to our active and large psychiatric service, seldom is a patient whose major problem is mental referred to the center without being under psychiatric care. Most of the referrals are for physical medicine services.

Rehabilitation centers contacted

	NUMBER
Inquiries	86
Replies received	78
Have program	23
No program	40
Anticipate program	15

"Occasionally, we also receive outpatient referrals from the local state mental hygiene clinic and our own part-pay clinic.

"In regard to statistics, I have none. My guess would be our mental patient caseload does not exceed 2%. We have always considered psychiatric patients as we would any others with additional supervision only when notified by the psychiatric department of any special precautions. Actually we have never considered them a problem. The physical disability patients seem to accept them tacitly. The socialization and group dynamics in the treatment areas have not been noticeably affected. It should be remembered that most of our mental patients are still quite acute and are often on treatment. More disturbing to the group are physical disability patients who are having difficulty with acceptance and are not having any help with their emotional problems.

"As noted in our brochure we are going to have 50 in-patient beds. Our administration feels that ultimately the psychiatric unit and ours will be coordinated. This will prevent unnecessary duplication of many services which are common to both. Our hospital has become so oriented to the idea of complete rehabilitation that our administration sees no need for separation of services to patients on the basis of diagnosis. I believe that psychiatric patients can benefit particularly from the vocational services of a center . . ."

CONNECTICUT

Rehabilitation Center for the Physically Handicapped, Inc., Stamford: "Originally, we just took workers with orthopedic handicaps. Later, in order to more adequately serve the needs of the community, we have taken workers with other disabilities including the epileptics, arrested T.B.'s, cardiacs, etc.

"Through the years we have had a limited number of emotionally disturbed workers in the sheltered shop. These workers have been under medical care and usually under medication. In our past experience we have found this group to be the most difficult and unpredictable of all the disabilities we work with. Periodically, for instance, one of them 'hears voices' and is talking with imaginary people. This can be very confusing and disrupting to the production of the other workers sitting near him. We have often felt that we would like to know more about how to

work with them—we feel the need of much more background in dealing with them.

"Our pre-vocational evaluation department and the sheltered shop are the two services used by this group in the past. Our pre-vocational evaluation department helps them determine a logical vocational goal, and the sheltered shop offers a work training opportunity as well as an opportunity for developing social relationships and work tolerance. We work very closely with the Connecticut State Bureau of Vocational Rehabilitation in those cases eligible for this service.

"Our medical board has been considering the problem of the disturbed and are aware of the situation that more and more ex-mental patients are being returned to the community and need help in 'bridging the gap.' The subject has been discussed at several of their meetings this past year. It is their feeling that the number of emotionally disturbed patients in pre-vocational evaluation and sheltered shop should be increased gradually. But they feel there perhaps should be some control as to the type and severity of the case. They are planning to add a psychiatrist to the medical board (a policy-forming group) to help them develop medical policy as it would relate to this group . . ."

IOWA

Department of Public Instruction, Division of Vocational Rehabilitation, Des Moines: ". . . we have served a number of ex-mental patients as well as mentally retarded persons. Our services to this group have consisted of personal adjustment training, vocational exploration and evaluation and on occasion some training . . ."

INDIANA

Crossroads Rehabilitation Center, Indianapolis: "Our work with mental patients has been quite limited. We do take a few from Central State Hospital, which is a state institution for the mentally ill, and from La-Rue Carter, which was set up as a screening institution for mental patients.

"As I said, we have a limited number of cases, taking approximately two per month. These patients remain under the care of the institution and spend their nights there, and days, of course, are spent at our center. To date we have had about 14 patients—two of them were, in our judgment, a complete failure. The other 12 have been completely rehabilitated; two of them are on our staff at the present time . . ."

MINNESOTA

University of Minnesota Medical School, Minneapolis: ". . . At the present time the rehabilitation center provides vocational services for psychiatric inpatients of the University of Minnesota hospitals. When the Department of Psychiatry believes vocational services are indicated for one of their patients, consultation with the Department of Physical Medicine and Rehabilitation is requested. An evaluation of the patient's resources in meeting the demands of the current labor market—which involves the use of intelligence, aptitude, proficiency and interest tests—is carried out as a beginning step. In addition to these methods, the prevocational unit of the rehabilitation center may be used to provide additional information, particularly that concerned with the patient's ability to adjust to competitive work situations. With the information provided by the Department of Psychiatry staff, the prevocational unit and testing procedures of the center, the vocational counseling section of the rehabilitation center can set up various programs or goals. For example, job placement services are available for those patients not directly employable, or sheltered workshop place-

ment for those patients who need a 'halfway house' type of program. The range of vocational services is continued to the point where the patient has either been successfully placed on a job or until it is felt that no further benefit can be obtained from the vocational services of the center . . ."

Duluth Rehabilitation Center, Inc.: "Our current rehabilitation program is set up to handle only patients who are in some way physically disabled. However, we do, when requested by a local doctor, accept occasional ex-mental patients for therapy in our occupational therapy department. Our reason for restricting the caseload has been, chiefly, that we do not have sufficient floor space or personnel to assume an additional number of patients. Also, we are a young center and were set up primarily to deal with physical disabilities.

"Like most growing centers, we do realize the need for help for the mental patient who has been released from direct care. We feel that if we are to be a true community rehabilitation center, we will someday have to assume the responsibility for offering services to these people. At the current time, our board of directors is considering the possibility of adding pre-vocational exploration services to our program. If this service is added, we will definitely make plans to include the mental patient. Work adjustment training will be of special importance. We feel, too, that as we are able to expand our occupational therapy department, we will be able to offer more, in that area, to the mental patient.

"You have undoubtedly heard of the Minnesota follow-up study which is currently being instigated here in Duluth. There is a very good possibility that our center will be utilized to help in assisting patients from this project back into everyday living. We will welcome the opportunity, especially if we are able, at the time, to expand our facilities and personnel . . ."

MISSOURI

Rehabilitation Institute, Kansas City: "We have worked closely with the Psychiatric Receiving Center located in Kansas City, and with the state hospitals, particularly those in St. Joseph and Nevada, in programs for their patients. Also, we have a good many referrals from psychiatrists in private practice. We have been working with the local Mental Health Association in providing services.

"Sometimes it is a program in occupational therapy including socialization for better adjustment to home. Others are accepted in our work evaluation and work adjustment unit for preparation for return to work or training. This program is carried on in cooperation with vocational rehabilitation.

"We have been doing some experimental work with patients who remain as inpatients at the Psychiatric Receiving Center but are brought to us daily for a program in work adjustment outside the hospital. If they adjust well, arrangements are made for their release and job training or placement is pursued. All resources of the institute for other services, as indicated, are available to these patients . . ."

Jewish Hospital of Saint Louis: ". . . As to our plans for the future we will be activating both adult and child psychiatric units later this summer and both these units initially will use selective services from the Rehabilitation Division. I am sure that as the program develops a more definitive program will be set up . . ."

Rehabilitation Center of Greater St. Louis: "Our program is with the neuropsychiatric patients who are receiving treatment and

under the care of a psychiatrist. They are outpatients except for a few who are in-patients of our state hospital and come to us for a period of adjustment before discharge."

NEW YORK

Rehabilitation Services, Inc., Binghamton: "In our sheltered workshop program we have various disabilities admitted on a percentage basis. This runs perhaps 5% or 10% either way; however, generally speaking only about 2% of the admissions to the workshop are of a psychiatric nature. Out of the present enrollment of 235 sheltered workshop workers there are 7 people that are in this category. This includes mental retardation, nervousness and mental treatment patients. To my knowledge the sheltered workshop does not plan any further expansion of this program . . ."

Tri-Lake Rural Rehabilitation Services, Saranac Lake: "In general, the Guild has been gratified by the progress of these cases although there has of course been a percentage of failure. The Guild has felt a particular obligation to service ex-mental patients since training facilities where adequate supervision was available are few and far between . . ."

Mobility Rehabilitation Services, Treatment Center and Workshop for the Physically Handicapped, New Rochelle: "Mobility has been involved in the after-care of mental patients for several years. We have not labeled it as such for various reasons and we have been quite selective, but the service has been definite and—we feel—productive.

"In our workshop we have accepted trainees with other than orthopedic disabilities. In fact, most of our trainees are cardiacs, inactive TB's, mentally retarded, accident cases who didn't respond readi to standard medical treatment, epileptic etc. Due to pressure from after-care pe sonnel, we have evaluated several ex-psy chotics and placed them in our shop. W have felt that their progress was at leas average. The benefits of working in sheltered, understanding environment, a work tolerance is developed, are undoubt edly known to you. We are in an excellen position to provide liaison with those othe community resources required by th trainee in his rehabilitation process. Ou focus is on integration of the trainee int a normal, competitive environment outsid of our shop.

"The limitations of such a service are a obvious as the benefits. Trainees with mental illness history require varyin amounts of close, readily available case work. This usually does not include b definition monthly visits to after-car clinics.

"For example, if we were to expand ou workshop services for the mentally ill, w would require a full-time psychiatric socia worker (or counseling psychologist) wh would be available at all times. Psychiatri consultation and psychological service would be required to help plan and super vise the individual programs. We feel tha the mental illness trainees who have lef the shop against advice might have re mained and been helped, if their day-to-da problems could have been met as they arose This was not possible through our present social services, due to the pressure of othe duties and the difference in focus of the job classification. In my opinion it is not realistic to expect the necessary psychiatri supervision for workshop trainees to be pro vided exclusively outside the workshop set ting. Ideally, there should be close coordi nation of supervision within the setting and without.

"From an administrative standpoint, the greatest problem is provision of the physical plant and production personnel necessary, if a work setting is to be provided. Mobility already has this and is building up its supply of subcontracts which provide work for the trainees. Despite an efficient management, subsidy averaging about $13,000 a year has been required to keep an average of 25 trainees working. The professional personnel needed to expand services for the mentally ill would necessitate additional subsidy. If the number of such trainees grew, a specially oriented floor supervisor would be needed for instruction and job supervision . . ."

Rochester Rehabilitation Center, Inc.: "During the past four years we have had convalescent psychiatric patients referred to the Center for Occupational Therapy and Work Evaluation in our industrial division and on two occasions for physical therapy. These statistics are as follows: 1954–55, 7 occupational therapy; 4 industrial division; 1955–56, 3 occupational therapy, 3 industrial division; 1956–57, 2 physical therapy, 4 occupational therapy, 4 industrial division; 1957–58, 2 occupational therapy, 3 industrial division. We have not been very successful having the psychiatric patients placed in competitive industry; however, we have found that they can adjust to a sheltered environment, such as exists in our industrial division. The main emphasis in the occupational therapy division for this group of patients has been one of helping them develop stability to meet new situations and to consider a vocational goal. We have also found that no matter in which division the patient is enrolled, it is definitely a long-term process . . ."

Institute for the Crippled and Disabled, New York City: ". . . we have limited our services in the past to those who have a physical disability. A substantial portion have had extensive emotional problems not unlike those of the mental patients. To deal with these problems we have incorporated in our services a licensed mental hygiene clinic staffed to deal adequately with such problems.

"Because of this psychiatric effort, we have been encouraged to consider the acceptance of mental patients being discharged from the mental hospitals or other mental health facilities. We are approaching this on a cautious experimental basis. A limited pilot program has been under way for the period of a year through the acceptance of referrals from the Brooklyn Day Hospital. We are now negotiating with DVR to accept a limited number of carefully prepared referrals from them. It is our hope to gain experience and insight into the problems of this type of patient and to determine if they can be assimilated with our other clients. If this preliminary work develops satisfactorily, we will then be able to extend our services to this group considerably.

"One of our expanded services is our workshop, which has moved into 18,000 square feet of rented space. We look upon this as one of the areas in which relatively long-term transitional employment may be offered to mental patients concurrent with the necessary psychiatric care. The end objective would be to return the client to gainful employment . . ."

OHIO

Goodwill Industries Rehabilitation Center, Cincinnati: ". . . One frequent program that we have is in connection with local hospitals, whereby the mental patient continues on an in-residence service at the hospital for nights and week-ends but comes to Goodwill for training and preliminary employment services until he is ready for discharge.

Transitional employment is offered to these and to other mental patients until they are capable of employment in competitive industry.

"Other programs include testing, counseling, work evaluation and social services in addition to those listed above for patients who have been discharged, or for those who are being seen on an outpatient basis . . ."

Vocational Guidance and Rehabilitation Services, Cleveland: ". . . The Greater Cleveland area has several private and state-supported psychiatric OPD's, neuropsychiatric wards and 'mental' hospitals. We share the responsibility along with the local Ohio BVR office for accepting referrals of mental patients to develop and follow through in a rehabilitation program. The BVR office recently placed a full-time vocational rehabilitation counselor on the Cleveland State Hospital staff to help identify patients who are ready for vocational rehabilitation planning.

"A survey of 150 clients admitted to our program between January and May 6, 1958 reveals 9% of them were referred because of emotional, mental or behavior disorders. There are others who are referred because of physical or intellectual disability who have an equally disabling mental or emotional problem. I would estimate this group at 25% of our total population.

"Our experience with mental patients has been interesting and has shown that many mental patients can benefit to some degree from vocational rehabilitation. We have had somewhat more success with the discharged mental patient who does not require continued medication to maintain his post-hospital adjustment. Even on medication there is some benefit in many cases.

"At the present time many of the referrals coming from mental hospitals are patients who live in the hospital and are being followed psychiatrically while they are activ in a rehabilitation program with ou agency. If employment can be secured, th patient is then released on trial visit for si months. In the meantime our vocation counselor is active with him from his initi contact through his employment and co tinues until he is vocationally stable . .

Goodwill Industries of Dayton, Inc.: "I 1957, we had 15 direct referrals from th Dayton State Mental Hospital. We ma have, and in fact did, work with other cl ents with severe emotional problems, but l is the number of direct referrals from th local mental hospital. The social servic department in the hospital referred thos dischargees to us for our specific service which are all vocationally oriented. Th means then that the social service depar ment of the hospital felt that the referra here were ready upon discharge to conside some vocational goal. Our major functio was to render one of the following voc tional services—vocational evaluation, wor adjustment, vocational training, sheltere employment or competitive placemen While receiving one of these services th client may have also been receiving cou seling from our own staff psychologist, fro our consulting psychologist or from re-visi to the outpatient department of the sta hospital. In several instances, the client c patient continued living in the state ho pital during the vocational evaluation pro ess, being released only upon the establish ment of a vocational objective. In near every case, the Bureau of Vocational Re habilitation participated in the program ming generally to the extent of sponsorin the client to service here . . ."

PENNSYLVANIA

Harmarville Rehabilitation Center, Pitt burgh: ". . . Heretofore, this center has bee

very active in the area of physical disability. We are now in the process of expanding to include patients who are emotionally disabled. It is hoped that some patients might avoid institutionalization and other patients be helped to return to the community, jobs and families, through a day-care program, with some inpatient beds where necessary. We hope to have this program in operation this summer, and are presently awaiting word from the State Department of Welfare regarding approval of funds from programming such a day-care activity for psychiatric patients . . ."

VIRGINIA

Woodrow Wilson Rehabilitation Center, Fisherville: ". . . During the past year our enrollment has averaged 375 resident students. Fifteen percent of these are mentally retarded and 5% had mental and emotional disturbances. A very large majority of our students with mental problems have come to us from the state mental hospitals. Some of our outstanding successes, as well as our outstanding failures, have been in this group. We have made no special plans for these students other than attempting to do a good evaluation of the student's potential for adjustment before accepting them. Once they are accepted a counselor is assigned who works closely with the student while he is undergoining a rehabilitation program. These students have adjusted well in our business school and in our nurse's aide training. We have also trained some of them in food service in our dining hall and canteen.

"At the present time we are talking with the doctors of the mental hospitals looking toward further coordination of the two programs. The patients are furloughed from the hospital to the center and we find that it is very helpful to be able to return the patient to the hospital if our psychologist or psychiatrist feels it is advisable . . ."

WEST VIRGINIA

Vocational Rehabilitation Division, State Board of Vocational Education, Charleston: Has served 41 ex-mental patients.

WISCONSIN

Curative Workshop of Milwaukee, Inc.: ". . . Our experience with mental patients is not too extensive; nevertheless, we have been handling both psychiatric and mentally retarded patients for many years.

"The psychiatric patients are usually referred by the patients' private physicians for occupational therapy, group socialization and sometimes physical therapy. During the past several years we have also been requested to provide vocational evaluation, counseling and placement services for patients recently discharged from various psychiatric hospitals. Our psychologist and social workers work closely with the patients' psychiatrists in developing and carrying out a suitable plan of action for these patients aiming at their maximum rehabilitation.

"Although we, at present, do not have any special formalized program of services for this separate group of patients, we have often discussed the advantages of such and believe there is a great need for an effective program of services especially geared to these patients.

"To date, the physically disabled have dominated our attention; however, I believe we are now in a position to give the mental patients more attention. I believe that a center of this type could easily gear a special program of services for the mental patients on an outpatient basis which could

effectively assist these patients in their total adjustment and rehabilitation . . ."

REHABILITATION CENTERS WITH NO PRESENT FACILITIES, BUT WITH FUTURE PLANS

COLORADO

Goodwill Industries of Denver: "Our Goodwill Rehabilitation Center has not had any experience in serving ex-mental patients but our plans include such service and we are hopeful of developing a program for these persons in the near future."

CONNECTICUT

Hartford Rehabilitation Center, Inc.: "We are currently investigating the possibility of providing rehabilitation services to mentally ill patients with both the local Veterans Administration and the Greater Hartford Association for Mental Health.

"We have been philosophically committed to the concept of serving the emotionally ill person since our association with the rehabilitation field. The limitations of facility, personnel, budget—and the initial attitudes of many of our own physicians—have all been obstacles to this development.

"Today, we can point with pride to a recently completed 2-year pilot study in rehabilitation services for the mentally retarded. We had the same kind of barriers to overcome here. We persisted and have demonstrated to the satisfaction of all that the comprehensive center can meet the needs of a selected population of retardates and that this group can be treated together with the physically disabled with resulting benefits to all concerned. . . .

"This gives us both the justification and increased initiative in pursuing our next major goal, that of services to the mentally ill. We are in the very exploratory phase of this undertaking, but have high hopes for the future."

DELAWARE

Delaware Curative Workshop, Inc., Wi
mington: ". . . 1) The Delaware Curativ
Workshop does not provide direct servic
to the victims of mental illness. 2) We d
have physical facilities and professiona
staff to offer such service in the future.
We would like to cooperate with relate
agencies in developing any programs
rehabilitation which might be indicated t
better serve Delaware."

INDIANA

Rehabilitation Center, Evansville: "Up t
this point our program has been limited t
persons with physical disabilities. How
ever, within the next two weeks we will b
moving into our new facility where we wil
have much larger quarters and potential
for very great increase in our service pro
gram.

"It is my personal feeling that as ou
program and staff do expand in our new
facility we should seriously consider th
inclusion of services for individuals recover
ing from mental disability. I would think
that the pre-vocational exploration unit in
our new center would be particularly
adaptable to the provision of services to
this group. In fact, I have had some very
preliminary conversations with the social
service administrator of our local state
hospitals about the development of such
a plan at some future date. Of course, the
prime consideration in the initiation of
services to mental patients would be the
question of availability of funds to finance
a program for them.

"It is my belief that rehabilitation centers
should have as their goal to develop pro-
grams of service to individuals with all
types of handicaps just as rapidly as the
need is demonstrated, competent personnel

are available and financial support is forthcoming."

KENTUCKY

Rehabilitation Center, Inc., Louisville: "Our future program plans include a broad sheltered workshop program that will enhance the training of the ex-mental patient and readjustment programs in association with the 'halfway house' that has been established here in our community. It is our hope to integrate services to the mentally retarded, cerebral palsied patient, and those with physical disabilities in this area. If we can develop such a program we hope we can interest industry in working with us in developing the modified industry area for permanent employment of those people who find it impossible to compete in regular industrial pursuits.

"Our future planning is not in the building stage as yet and we, of course, are among the many faced with the problem of acquiring funds for the development of such a program . . ."

MASSACHUSETTS

Boston Dispensary: "We have given considerable thought as to how the rehabilitation institute at the Boston Dispensary might be of value in a mental health program . . .

"It would seem to us that we could be of value in doing vocational evaluation and occupational therapy and pre-vocational testing in connection with post-hospital planning for mental patients. We have a good psychiatric clinic in the dispensary and a full-time clinical psychologist in the institute, in addition to the social worker and vocational counselor to assist the therapy group. There is also a possibility that our psychiatric service may be considerably expanded in the fall and, if that should take place, we could certainly participate in periodic follow-up and re-evaluation of post-hospital patients."

MICHIGAN

Detroit League for the Handicapped, Inc.: "We are seriously considering this project in our future planning, but of course, we cannot at this time determine the extent of service we can or will be able to give in this field."

Rehabilitation Institute of Metropolitan Detroit: "To date, we have not specifically admitted any patients who have a primary diagnosis of mental illness . . .

"In the future, we do not know exactly what the development along this line will be. Certainly, we are established in Detroit to provide comprehensive services for the patients within this area. If a need develops in the sphere of mental illness and if we have services which significantly offer these people a better opportunity to return to their communities healthier and better able to adjust to their future lives, then I am sure we will endeavor to set up programs which will help them . . ."

NEW YORK

New York University-Bellevue Medical Center: "Unfortunately, we have not had any real experience in providing services to ex-mental patients at the institute.

"This has been under discussion, however, for some time and I am forwarding your letter to the director of Psychiatric Services Division of the institute, and I know that he will write to you directly, informing you of whatever thinking is now taking place on this matter.

"I am sure that there is a great need for this additional service in the field of re-

habilitation and I am glad to see some action in this direction."

Chronic Disease Research Institute, University of Buffalo: "We are a medically oriented physical medicine and rehabilitation center, and therefore are limited as to the types of services which can be offered to ex-mental patients or patients on convalescent care. We realize that there is a great need for rehabilitation services to such patients, and the Buffalo Council of Social Agencies is in the process of completing a survey as regards broad rehabilitation for this community. As I have been an active participant in this survey, I know that one of the strong recommendations will be for a more comprehensive rehabilitation center which will offer services of social adjustment and work adjustment and tolerance for the type of patients mentioned in your inquiry, in addition to the services now available."

OHIO

Rehabilitation Center of Summit County, Inc., Akron: ". . . the Rehabilitation Center of Summit County has not provided such services.

"The Rehabilitation Center does not have a workshop or a work evaluation area at present. We sincerely hope that such a workshop can be developed soon. Our obstacle here, of course, is funds to equip and staff it. However, our immediate future plans do call for workshop and work programs and upon their development we would certainly offer such services (along with our present services, psychologist, vocational counseling, social worker) to ex-mental patients and to the mental health program . . ."

Ohio State University, Columbus: "My notion would be that probably sheltered workshops have offered more to this group th have rehabilitation centers. The Ohio R habilitation Center has not yet accepted patient from this category as such, but has no policy which would categorical deny services to such patients . . .

"We maintain a part-time psychiatrist this staff as well as a psychologist and tv social workers. We insist on interpreti our psychiatric services as an adjunct physical, social and vocational rehabilit tion; however, one of our problems growi out of this fact has been the request f service in an increasing number of instanc to people who frankly need psychiatr help, but for one reason or another do n choose to ask it from an avowedly ps chiatric institution.

"I would feel that as sheltered worksho are developed, either in conjunction wit rehabilitation centers or through the add tion of professional rehabilitation servic to those now available, that much mo might be done for the mental patient."

PENNSYLVANIA

Home for Crippled Children, Pittsburgh "We are *very, very* seriously exploring th possibility of inaugurating such services an are currently conferring with appropriat community persons, including universit staff people to see how we might be o service. We are talking in terms of preven tion as well as post-hospitalization service for children. At the moment it is no mor than early, exploratory planning, but think it infers an attitude."

Rehabilitation Center, Hospital of th University of Pennsylvania, Philadelphia "As this is a teaching institution, we ar very much interested in rehabilitation o the mentally ill. However, it is my opinio that centers for the physically disabled ar not suitable for that type of program. First

the usual professional staff is not trained adequately to treat these patients. Secondly, mixing the physically disabled patients with the mentally disabled will have adverse effects upon both groups.

"Ideally, centers should be established which serve the mental patient exclusively and which provide an integrated comprehensive approach.

"It is quite possible that as our program develops we can undertake this project. We have a University Rehabilitation Commission which is active and interested, thereby providing the ideal environment for developing resources.

"Available funds would hasten the process.

"As part of my community activities I have been working with a sheltered workshop in establishing a service for the mentally ill, so that I am well aware of the magnitude of the problem and the present lack of adequate facilities."

BRITISH COLUMBIA

G. F. Strong Rehabilitation Center, Vancouver: "The government of this province operates an excellent Provincial Mental Health Center which provides rehabilitation services to those patients who can benefit from such services."

Although the statistical data in this brief survey are too small for significant conclusions to be drawn, it seems that the qualitative experiences of the rehabilitation centers quoted above point strongly to the feasibility and desirability of including ex-mental patients in rehabilitation center programs (of which there are some 350 at the present time throughout the U.S.). Above all, the experience of 23 rehabilitation centers demonstrates that the ex-mental patient can not only benefit from rehabilitation services, including sheltered workshops, but that his co-mingling with other types of handicapped persons presents no obstacle or difficulty for others simultaneously involved in the rehabilitation process. Significant, too, is the fact that the lack of funds is frequently a critical factor in the inability of rehabilitation centers to develop, or expand, services to mental patients.

C. S. BLUEMEL, M.D.

If a child stammers

There is an old belief that children stammer because they think faster than they can talk. This is very nearly correct. Actually a child does much of his thinking in eagerness and excitement, and he has many feelings and frustrations that could never be put into words. And even if he could calm his feelings and try to think his way into speech, he would often lack the vocabulary to express himself. He would then encounter a speech block—a sort of road block in word-thinking.

Halting and repeating and backtracking are normal phases of speech in a child's developmental years, and the symptoms should cause no anxiety. This commonplace stuttering is nothing more than speech in the making. It is immature speech; it is trial-and-error speech. It is speech that is not yet organized into a pattern that the child can use and control. Yet children differ in their natural fluency. In genera girls are more fluent than boys. But apar from sex, some children are highly skille in speech and others are peculiarly inep It is the inept children, of course, wh stutter more when they are learning to talk But usually these handicapped children de velop a satisfactory degree of fluency, an in the long run they are not far behind th more skillful pacemakers.

A child learns speech by imitation— much of it, of course, unconscious. H learns the language that he hears, be i English or Chinese or Choctaw. And h learns good speech or bungled speech ac cording to the manner in which the word are presented to him. He cannot learn good speech from the baby talk of other children he learns only by hearing clear speech in the adult pattern. Twins talk poorly be cause they listen to each other. The only child in a family talks well because he listens to the mature speech of his parents. Actually few children have the opportunity of learning good speech by absorbing good

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speech patterns. Most children catch their speech in much the same way as they catch measles—by being exposed to it.

The child is obliged to catch his speech because there is no natural division between words as he hears them. He is in much the same position as the beginning student who is learning a foreign language and can make nothing out of a running conversation. Yet the student understands short phrases, and the foreign words make sense when he hears someone say *bon jour,* or *guten Morgen,* or *buenos dias.*

It can be seen that the child has considerable difficulty in learning speech because the words come to him in telescoped form. Naturally his difficulty is multiplied if he has to learn two languages at once. His parents may speak German, while his playmates speak English. Or the family may emigrate just when he is beginning to learn his native language, and he is thrown into bewilderment by a new language he cannot understand.

Even when a child is learning a single language the learning process is seldom easy. In this developmental period, while the child is "making" his speech, he encounters stresses which tend to "unmake" it. His speech may seem normal enough during this period, yet it may break under the stress of excitement, fatigue or frustration. The resistance of speech to stress is somewhat like the resistance of ice to weight. Ice that is half an inch thick on a lake looks the same as ice that is four inches thick; but while the thinner ice will barely carry the weight of a man, the heavier ice will sustain the weight of an army. One cannot, of course, compare ice with speech, but it can be said that when speech is securely organized it can tolerate the weight of considerable stress.

The thinly organized speech of a child is easily broken by such common stresses as the excitement of a party or picnic. Fluency is even more likely to break under the sustained excitement of Christmas festivities. Speech is often disturbed by the fatigue of travel, camping trips and other tiring activities. There are many experiences which overstimulate the child and disrupt his tranquility; but while most of these stresses have only a temporary disrupting influence there are some experiences which may have a lasting detrimental effect. Such, for instance, are the experiences of shock—the shock of a fire, a flood, a fall, an automobile accident or any misadventure which carries the semblance of disaster.

Less conspicuous influences also break a child's speech, and here we can include the sustained stresses of anxiety and frustration. The child's fluency may suffer under the stress of family discord, the daily fear of a harsh teacher, or the menace of a bullying playmate. Fluency may also be disturbed by the nervous nagging of anxious parents who constantly "correct" the child's speech and thus make him self-conscious and apprehensive. In speech, the area of stress is particularly broad, and the speech function may be disturbed and impeded by any severe or sustained stress which exceeds the child's uncertain tolerance.

The functional upsets in a child's life are not, of course, limited to speech. Stress may disturb a child's sleep, his appetite, his digestion, his bladder control and countless other functions. There are natural limits to the tolerance of stress—and this applies to the adult as well as the child. When these limits of tolerance are exceeded something is sure to give. The reaction may take the form of insomnia, night terrors, loss of appetite, vomiting, facial twitching and so on. The reaction may also take the form of stammering, the particular functional disorder that concerns us.

Though the speech disturbance of stam-

mering appears to be simple, it is, in reality, complex. The initial disturbance, the primary stammering, is an intermittent inability to talk—or to talk with accustomed fluency. And as if this were not enough, the primary stammering soon takes on a secondary phase. When the stammerer's speech becomes blocked he tries to force the utterance of his words, and he enters upon an unnatural phase of effort and struggle, and sometimes contortion. He may even use his fists and his larger body muscles in a futile attempt to articulate. Meanwhile, his breathing is disturbed, and he holds his breath or attempts to talk after exhausting air from the lungs. In primary stammering, the thinking process is already confused, but in secondary stammering the speaker becomes more disorganized as he tries frantically to escape his dilemma by searching for synonyms and round-about expressions. Phobia adds itself to the picture; the speaker now becomes fearful of difficult words and of ominous people and situations associated with his former speech frustrations. All of this secondary stammering is added to the primary speech disturbance, and the final predicament of the speaker may be severe and bewildering.

And now the question: How can speech impediments be avoided—the stuttering of speech in the making, and the stammering of speech in the unmaking? The stuttering of early speech, or pre-speech, is normal, and ordinarily it should not cause alarm. Yet the repetition and halting may be excessive, and the broken pattern of speech may turn out to be the forerunner of stammering. For this reason impeded speech cannot always be ignored. Nervous and excitable children often make and unmake their speech in alternating phases; when the unmaking predominates, stammering is sure to follow.

At this juncture in the child's life the problem is to organize his speech—to organize it into a pattern of natural fluency. This procedure not only reduces the stuttering, but it safeguards the child against the subsequent development of stammering. The organizing process is, of course, nothing more than the learning process. To learn good speech the child must clearly distinguish the words that he hears. But commonly the words of adult speech run together—theyruntogetherlikethis. They run together like the conversation in French or German that we hear when we are traveling abroad. We can understand the child's dilemma in distinguishing speech sounds when we consider what a task it would be to read the morning paper if all the words were merged into an endless polysyllable. Yet this is the kind of polysyllable the child hears in adult conversation. To his inexperienced mind the words are all linked together in challenging confusion.

Here the child needs speech training in which the words are unlinked so that he can understand them. The parents can help the child by speaking slowly, clearly, and in short sentences. Thus by a process of ear-training they present a pattern of speech from which the child learns easily and naturally. In the natural steps of learning the child first hears words with unmistakable clearness. Then he remembers the words. Then he is able to think the words. Then he can say them. Admittedly this formula is oversimplified, but it emphasizes the logic and the necessity of ear-training. Of course the parents cannot engage in ear-training throughout the day, but they can speak in slow and measured phrases often enough to provide the child with a stable pattern of speech which he adopts for himself.

An agreeable form of ear-training consists in reading to the child from a storybook or picture book. Again the sentences are short and clear. "Once upon a time – there were

three bears – a papa bear – a mama bear – and a baby bear." Here the child identifies the words, and he learns as he listens. Soon he will want to join in the "reading" as the game proceeds. Of course he follows the pattern very poorly while his speech is new; nonetheless he learns in his own way and in his own time. Meanwhile, he is not *taught* to speak. He is given a clear pattern of speech, and he does the learning by himself. When he makes mistakes he is not corrected; and when it is his turn to talk he is not interrupted.

Phonograph records can be used to promote the learning process, and they add considerably to the opportunities for ear-training. Recorded songs are as useful as rhymes and stories—provided the words are clear. The mother repeats a few words as a record is played, and the child eagerly joins in the talking game. Occasionally a radio or television program can be found that will supplement the records, though the speech will have to be clear and slow if it is to have ear-training value. Throughout, the sensory training is informal, and it takes the pattern of a game. Yet the games establish the function of speech in an unbreakable pattern, and they furnish the child with lasting fluency.

This process of "making" or organizing speech can also be used effectively when the child's speech is in the process of "unmaking." The speech function which has become disorganized must be repaired or reorganized. There is little need to pay attention to the stammering itself, for this is merely a symptom—like the spots in measles. In speech therapy the parents endeavor to re-establish the normal pattern of fluency. The child must hear and feel himself again talking normally, and he does this as he listens to slow and measured speech, and repeats the words or accompanies them. This repairing process should be done early in the course of the speech disorder; otherwise, the abnormal speech may itself become established as a lasting pattern.

Meanwhile, of course, the disorganizing stresses in the child's life must be identified. There may be too much activity and excitement and too little calm in the daily program. There may be too much competition for speech at the family table, and no one may be listening when the little fellow is trying to talk. Still worse, an older brother or sister may snatch speech away from him, and thus put him at a constant disadvantage. Whatever the disturbing stresses in the child's life, they should if possible be removed.

Adequate bed rest is important for the child who is overstimulated and easily disorganized. When such disturbances as facial twitching, bed-wetting or stammering suddenly appear, the child can be helped by a few days of bed rest. The rest will be more beneficial if it is fortified with a sedative—given, of course, under medical direction.

A tranquil home is important for the nervous child, for it tends to establish the inward composure that is necessary to normal speech. Yet in the child's developmental years, composure is easily lost and speech readily becomes disorganized. Fortunately, parents can safeguard the child in these situations. They can help him and guide him in the simple skills of word-thinking and thus they can assure him the fluency that he will need in daily living.

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Attitude change in member of parent education course

All educators must have faith in the educational process to bring about changes in the members of their classes. It is usually desirable, however, to have an adequate evaluation of the results so as to know both the extent and the nature of the changes produced. This is as true of parent educators as it is of any other type of teacher.

Many attempts have been made to measure the effect of participation in parent education courses. Some of the questions the parent educator seeks answers for are these: What attitudes in parents would seem to best foster healthy development in children? Does attendance at parent education groups encourage these attitudes? Does a parent's attitude change as a result of a tending a group and is the change in th best interests of his child?

The method most frequently used to g answers to these questions is the questio naire, filled out at the beginning and en of a series of meetings.[1] The usual concl sion of such studies is that attendance such groups does result in a change of at tude and further that the change is in direction that parent educators would co sider desirable.

However, the questionnaire method not completely satisfactory. There is th suspicion sometimes that the members ma try to give the answers that they believe th leader expects. Also, the questions aske are sometimes "leading" questions so th the answers may be more a reflection of kind of verbal learning and not necessari an indication of a change of attitude.

All four authors are members of the staff of the Institute of Child Study of the University of Toronto.

[1] Examples of such studies are given in Monograph 17 published in 1939 by the University of Minnesota.

The "Q" technique described by Stephenson [2] and used by Rogers [3] to measure personality change as a result of psychotherapy seems to offer the type of measure required. By this method it is possible to determine the degree of relationship between different sorts of statements. For example, the subject could be asked to sort the statements to conform with how he views himself as a parent, and with what he thinks an ideal parent is like. Then the "Q" can be calculated to indicate the degree of relationship between the two sorts. Or the sort at the beginning and the sort at the end of a course can be related to determine if there has been any change in how he views himself as a parent. If suitable material (statements) can be assembled, the details of administration are relatively simple. The subject sorts the statements (on cards) into a forced standard frequency distribution according to specific instructions. The relationship among various sorts can then be determined.

In the present study 684 statements about parenthood were collected from members of parent education groups. From this pool 50 statements were so selected as to provide a wide range of parental attitudes ranging from a high degree of adequacy to extreme inadequacy. This selection was made by the four authors individually and in consultation with each other. Each statement was carefully studied for relevance and for possible ambiguity or obscurity. The main concern at this stage was to get clear, easily understood, unambiguous expressions of parental attitudes in a wide range from the highly desirable to the highly undesirable.

These statements were used with a group of parents who were members of one or another of three parent education courses being conducted at our institute at the time. Although the three courses varied in content they were conducted by staff members and were fundamentally similar in their philosophy of child training to that of the institute. Each course consisted of ten 2-hour meetings held weekly. The form of the session varied but was in the main a combination of lecture and discussion. The data reported here came from 39 group members for whom complete before and after sorts were obtained.

Each member was asked to sort the statements twice at the first meeting of the course and twice at the final meeting. On each occasion the statements were sorted first as a "self" sort and then as an "ideal" sort. For the "self" sort the statements were placed in a forced normal distribution of nine categories ranging from "most like myself" to "least like myself" as a parent. The "ideal" sorts used the same distribution but this time "most like" and "least like" were in terms of "what I think a parent should be." "Group ideal" values were obtained by combining the ideal sorts of all subjects. "Q" values were then calculated for the following: self 1—ideal 1; self 1—group ideal 1; ideal 1—group ideal 1; self 2—ideal 2; self 2—group ideal 2; self 1—self 2; ideal 1—ideal 2; self 2—ideal 1; self 2—group ideal 1; and ideal 2—group ideal 2. (The numeral 1 refers to the sort at the beginning and 2 to the sort at the end of the course.)

From this wealth of material—10 sets of "Q's" for each of the 39 members—some interesting conclusions can be derived. It can be seen that the people who come to parent education courses differ widely in the way they think of themselves as parents.

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[2] William Stephenson, *The Study of Behavior: Q-Technique and Its Methodology*. Chicago, University of Chicago Press, 1953.

[3] C. R. Rogers and Rosalind F. Dymond, *Psychotherapy and Personality Change*. Chicago, University of Chicago Press, 1954.

If we can accept a difference between the "self" picture and the "ideal" picture as meaning that the individual feels inadequate as a parent, then we can say that approximately half the group felt inadequate; some others, with self and ideal pictures almost the same, felt adequate.

The range in "Q" values for the self 1—ideal 1 was —.11 to .95 with a median value of .58. This would seem to indicate that parents coming to parent education courses do so for a number of reasons. It might be possible to sort the parents into two groups, those with low Q's needing an increase in self-confidence and parental skills and those with high Q's who may need a different kind of experience designed to produce a more thoughtful and less complacent attitude.

Our main aim was to try to determine whether there was a change of attitude resulting from participation in the course. One indication of this would be a change in the magnitude of the "Q" in a comparison of the self 1—ideal 1 and the self 2—ideal 2 sorts. That is, do the self and ideal pictures become more alike or farther apart? If we accept a change of .1 or more as significant, then we find that 18 (46%) show a change towards a greater similarity of pictures, 7 (18%) a change in the opposite direction and 14 (36%) show no significant change of this nature. However, when the two pictures are close together at the beginning (high Q's) there is less possibility of change towards greater conformity. The ten with the highest self 1—ideal 1 Q's showed no significant change in this direction, but three of the ten showed a significant change in the opposite direction—that is, less similarity between self and ideal pictures. On the other hand, nine of the lowest beginning Q's showed a change towards greater similarity in pictures, and presumably felt more adequate as parents after the course. Participation in a parent education course does seem to be effective in bringing the self and ideal pictures closer together when they are far apart to begin with.

Was the change that occurred in the way the parents viewed themselves as parents or was it a change in their ideal picture of a parent? An inspection of the self 1—self 2 Q's indicates considerable change in the self picture during the 10 weeks of the course. These Q's ranged from .04 to .8[illegible] with a median Q of .69. The change in the ideal picture is less pronounced, the range of the ideal 1—ideal 2 Q's being from .2[illegible] to .90 with a median of .79. Nine of the group had a self 1—self 2 Q below .60 while only three had an ideal 1—ideal 2 Q that low. Sixteen had ideal 1—ideal 2 Q's over .80 while only nine had self 1—self 2 Q's of that magnitude.

These values would seem to suggest that attendance at a parent education course brings about a greater change in how the person views himself as a parent than in his picture of what a parent should be like. It may very well be that most of the subjects had a fairly adequate ideal picture of parenthood and needed very little change in this regard. This is indicated by a correlation of .95 between the beginning group ideal and the final group ideal. And also when the group ideal was compared with a combined sort made by the three leaders of the parent education groups the resulting coefficient was .85, so that the picture of an ideal parent held by the members was very similar to that of the leaders. With the kind of people who come to these groups there seems to be very little need for education in parental ideals but rather for an emphasis on how to become more like the parent they think they should be.

An examination of the placement of the statements in the various sorts indicates considerable stability. For example, the stand-

TABLE 1

Summary of Q values for selected cases

CASE	S_1I_1	S_1GI_1	I_1GI_1	S_2I_2	S_2GI_2	I_2GI_2	S_1S_2	I_1I_2	S_2I_1	S_2GI_1
5	—.11	—.10	.71	.68	.68	.61	.04	.65	.56	.66
31	—.11	—.07	.83	—.06	.07	.87	.66	.86	.06	.12
45	.52	.32	.62	.20	.53	.59	.51	.45	.51	.61
44	.88	.78	.69	.91	.80	.79	.86	.84	.84	.78
20	.94	.79	.83	.49	.54	.56	.57	.58	.58	.51

ard deviations of the placements in the self sorts ranged from .27 to 1.86 and in the ideal sorts ranged from .67 to 1.57. Although considerable variation in placement of the statements in the self sorts is to be expected, if the variation in the ideal sorts is too great the statement is probably not a good one. An examination of the distributions of placement of statements in the ideal sorts indicated that only three of the 50 statements are questionable. These statements will be modified in the next application of the material.

A simple 5-item questionnaire was used at the end of the course. The results indicated that, as is usual, the members answered the questions in a manner complimentary to the course and the leaders. Of the 38 who completed the questionnaire, all but five said the course changed their attitude to their child; all said the course increased their understanding of children; all said the course increased their skill in guiding the child; all but five said the course changed their ideal of what a parent should be like, and 27 said the course did not produce any confusion about what to do when difficulties arise.

A correlation of total score on the questionnaire with the self 1—self 2 Q's resulted in a coefficient of —.28. This would seem to indicate that the Q-sort technique is measuring something different from the more direct questionnaire. We could speculate that the questionnaire provides an indication of a kind of intellectual change and the Q-sort taps a more basic attitudinal change.

A detailed examination of the results for a number of selected subjects was made. A brief summary of this examination is provided here to indicate how the material can be used to gain insight into what happens in individual cases in parent education. A summary of the Q values for these five cases is given in Table 1.

SUBJECT 5

This is a mother of three children attending her first parent education course. In the first sort her self picture is very different from her ideal, although her ideal is very similar to that of the whole group. At the end of the course her self picture has changed considerably and now conforms fairly well with her ideal and the group ideal. Her ideal picture has remained fairly constant as the self picture changed. We would expect that with her original self picture so different from her ideal picture before the course she felt inadequate as a parent, but that after the course as the two pictures are more nearly alike she now feels more adequate as a parent.

The nature of the change that has taken place can be seen by examining the change in placement of statements. Some details

are worth noting. She is now more aware of what her child is doing and nags less. She is less influenced by the way she feels and trusts the child more. She shouts at her child less and acts less on impulse. On the whole, she gets along better with her child. She seems to have a better understanding of her role as a parent, and it seems safe to conclude that the course has been very successful for her.

SUBJECT 31

This is a mother aged 50, with one child, attending her first parent education course. In the first sort her self picture is very different from her ideal, which conforms closely to that of the group. At the end of the course there is very little indication of change. Her self picture is now similar to the original and still far from her ideal. It would seem that the course had very little effect, and one could guess that she would feel about as inadequate after the course as before.

On the other hand, an examination of her answers on the questionnaire shows that she thinks the course changed her attitude, increased her skill and understanding and produced no confusion. One could speculate that the changes are rather superficial and wonder whether individual counseling, rather than a parent education group, would be more helpful.

SUBJECT 45

This is a mother of four young children, attending her first parent education course. There is moderate conformity of her self picture and her ideal at the beginning of the course. Some change is indicated as her two self pictures show only moderate similarity. There is even less similarity in her ideal pictures so that there has been change in both self and ideal. It is difficult to t whether the changes result in more or l adequacy as a parent.

The questionnaire shows that she thin her attitude has changed and that her u derstanding and skill have increased b that the course produced some confusi as to what to do when difficulties arise. P haps this parent was looking for speci answers to problems and was not led think through her problems in the light principles. Again one could speculate th this parent needs a more prolonged pa ticipation in a parent education progra to profit from it.

SUBJECT 44

This is the mother of two young childre attending a parent education course for t first time. At the beginning her self pictu and her ideal picture are very similar a though her ideal is only moderately simil to the group. There are only slight chang indicated at the end of the course, her ide picture now being more like that of t group and her self picture very similar her slightly changed ideal. There is no ind cation that she came to the group becau of a feeling of inadequacy as a parent b rather that she, a "good" parent, came i the hope that she could become even bette Perhaps this indicates the necessity of pr viding parent education courses for diffe ent parental needs.

SUBJECT 20

This is the mother of one young child. A the beginning her self picture and her idea picture were almost identical. At the end o the course her self and ideal were farthe apart due to changes in both her self an ideal pictures. This seems to be the pictur of a fairly complacent parent who, becaus

of the course, was led to change both her ideal of parenthood and her picture of herself. This illustrates another function of parent education—namely, to bring about a more thoughtful attitude and less complacency. One can hope that this kind of change would make for better parenthood even though it may be disturbing to the parent temporarily.

SUMMARY

The Q-sort technique promises to be a valuable way of assessing the effects of parent education programs. It seems to provide a method of tapping more fundamental attitudes and attitude change than the more direct questionnaire method.

As would be expected, parents come to parent education courses for a variety of reasons. Some come because they feel inadequate as parents while others come out of curiosity or to increase their knowledge of child development. It may very well be that some method of sorting out members and providing different kinds of programs to meet different needs is indicated. The Q-sort technique may be one method of doing this.

At the present time the people who present themselves for parent education courses seem to need to learn how to become more like the parent they would like to be than to learn more about what the ideal parent is like. At least, it does seem to be clear that parent education courses such as those conducted at the institute are more effective in changing parent attitudes and behavior than in changing their goals and ideals.

This attempt to assess what happens to members of parent education courses is encouraging in that there are clear indications that change does take place and that it seems to be in the main in the desired direction. However, there are also indications that the program is not being effective with all and that some other procedure is called for in some cases.

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DALE C. CAMERON, M.D.

Characteristics of communities successful in organizing local mental health services

In a recent article [1] we reported on the impact of state grant-in-aid legislation in stimulating the development of community mental health services in Minnesota. The initial acceptance of the legislation and the willingness of inter-county units of government to finance the services has been striking. While our Community Mental Health Services Act of 1957 must be considered an important stimulus, the community dynamics and characteristics which culminate in the establishment of a local mental health center color the process of organization in ways deserving of study.

Dr. Hodges is psychological consultant on community mental health services and Dr. Cameron is medical director of the Minnesota Department of Public Welfare.

[1] Hodges, Allen and Dale C. Cameron, "Minnesota's Community Mental Health Services," MENTAL HYGIENE, 43(1, 1959), 111–14.

Within a 12-month period five regional units encompassing 17 counties applied for state funds. Meetings were held, newspaper editorials written, mental health study committees appointed. In most instances total community resources were mobilized with the result that all 17 counties appropriated county tax funds to match state funds. In this development each community showed unique individual differences.

Three characteristics were observable, however, and appeared common to successful efforts within each community. It appears likely that these three community characteristics underlie the organizational successes so far experienced.

WELFARE BOARD LEADERSHIP AND COMMUNITY INTERPRETATION

In 1953 the State Division of Social Welfare and the Division of Public Institutions

were consolidated. The Department of Public Welfare emerged, consolidating in one unit of state government all responsibilities centered around county welfare board operations and the total mental health program. The close liaison between these two service activities increased communication on all levels. Because of community respect for the county welfare boards' efforts to serve the needs of their clients, these boards today are some of the most valuable channels of communication to Minnesota citizens. In addition, in their services to their clients these boards encounter daily the social and economic aftermaths of mental illness and mental deficiency. This combination of awareness of need and knowledge of program planning places the boards in a position of strong leadership. Within all five successful areas the personnel of the county welfare boards have taken a major role in surveying community néeds, serving as resource persons to interested groups, and planning the actual program.

PLIABLE SECTIONALISM

In the five areas under consideration, each community firmly believes that within the whole state of Minnesota *it* is the most progressive and must be considered the best community in the state. This partisan pride is evidence, for example, in support of local athletic teams, pride in school building programs, and strong competitiveness in bidding for local industrial development. (At the time of this writing, state-wide studies related to the establishment of additional centers for higher education are underway. Three of the five areas that have established mental health centers already have colleges in their immediate geographic area and the remaining two are among the leaders in attempting to locate institutions of higher learning within their areas. It appears that not only are developments occurring in planning local mental health facilities but these five communities are planning ahead in other areas as well.)

Flexibility and pliability are also present in these successful areas, tempering their intense community pride. Under provisions of the Community Mental Health Services Act a minimum population of 50,000 is required. With the typical Minnesota county having approximately 18,000 population, counties of necessity must band together. In one region, relations have been strained for many years because of the division of one county into two separate counties. Owing to their common recognition of community mental health needs, these two counties united cooperatively with several other smaller counties to establish a local mental health center.

Intense sectionalism definitely appears to be a necessary characteristic of successful communities, but with fluid boundary lines defining the geographic area to be served.

EMERGENCE OF NATURAL LEADERSHIP

In all instances, our initial interpretation of the Community Mental Health Act has been on a broad educational basis upon invitation from interested groups such as PTA's, district welfare conferences, local mental health associations and service clubs. No concentrated effort was made to recruit support from community leaders or professional groups. Efforts were made, however, to enlist the support of the newspapers so that information could be broadly disseminated.

When invited to address interested groups the state consultants attempted to interpret the role of a local mental health center in the community and the realistic expectations that a community might have regarding the services of the center. The major

emphasis in interpreting the program was placed on the underlying philosophy of the program: Local Control with State Support.

With this initial structuring, successful communities demonstrated sufficient interest to invite resource persons from within their own community—such as welfare board social workers, physicians and ministers—to present their observations concerning the need for local mental health services. Guest speakers from the Department of Public Welfare, Minnesota Association for Mental Health, Department of Health, and University of Minnesota were invited to give a broader perspective of state and national thinking relating to the feasibility of the local mental health center as a community resource in promoting mental health.

Throughout this interpretative phase the leadership and creative thinking of this loosely organized, interested group evolved through certain respected spokesmen whose leadership in other civic programs had already been demonstrated. Contrary to the sometimes voiced opinion that most community leaderships are crusaders for mental health because of personal difficulties, leadership appeared to emerge from already established influential figures in the community whose civic responsiveness had been previously demonstrated.

SUMMARY

Certain behavioral characteristics of communities successful in planning for local mental health services have been discussed. While each of the five areas demonstrate individual differences in organizational procedure, three common characteristics are observable. The leadership of local welfare boards in interpreting the program in the community, strong sectional pride with fluid boundaries, and the utilization of previously established community leadership appear to be these three major influences in the development of community mental health services in Minnesota.

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Family structure and alcoholism

Alcoholism, like other forms of behavior defined as socially deviant by our culture, poses a particularly difficult adjustment situation for the family. The cultural norms governing the behavior of family members towards one another directly conflict with the prescriptions for behavior of members of the society in relation to social deviants. As a result family members are constantly in conflict over their adjustments. In addition, crises evolving from socially disapproved deviant behavior are left unstructured by the culture. The family facing this situation must resort to trial-and-error behavior in its attempts to control the deviant and to bring him back into line with social expectations. At the same time it is held at least partially responsible for his behavior. By definition a good and adequate family is one whose members behave in accordance with social expectations. Thus in its efforts to handle the problems associated with deviancy the family labors under a pall of blame. Its members feel guilty, ashamed, inadequate and, above all, isolated from social support. Where the husband is the alcoholic this burden falls disproportionately on the wife who, in her own and in society's view, has failed in her major roles.

The situation of alcoholism is even more complicated by the discrepancy between the accepted stereotype of the alcoholic and the realities of alcoholism. Only an infinitesimal proportion of all alcoholics approximate the constantly inebriated, de-

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socialized Skid Row bum, who is in a far-advanced stage of the disease. Most alcoholics, until well along in alcoholism, spend the greatest part of their time sober and handling their roles in a socially adequate manner. The discrepancy between the stereotype and the reality blinds the family to the nature of the situation for a prolonged period of time and interferes with constructive, planned behavior. The crisis mounts to considerable intensity before the family is able to comprehend that the alcoholic's behavior is involuntary and cannot be handled by any of the usual methods of social control. When the family arrives at this accurate perception of the situation, constructive reorganization usually occurs within a brief period of time.

Until this time the family's history is one of chameleon-like shifts in structure and member roles, in the alignment of relationships within the small family group and within the families of the parents. At any given stage of alcoholism the family's structure is related to the degree, duration and type of alcoholism, to the present state of the alcoholic (that is, whether he is drunk or sober) and to the type of concurrent subcrises, which usually accompany alcoholism. In addition, the family's behavior is conditioned by its relationships and action in earlier stages, which places limits on the actions it is possible for them to take in this stage.

Despite this, certain broad trends are observable which vary in content but not in broad outline from family behavior in the face of other types of prolonged and cumulative crises. The crisis begins as a series of acute crises, usually widely spaced in time, passes into a progressive type of crisis during which the emotional involvement and hostility expressed are diminished, and finally, if the family stays together, into an habituated crisis which is minimally disrupted by the behavior associated with alcoholism. Secondary crises of both the acute and cumulative type also arise and go through stages similar to the over-all pattern.

There are distinct stages in the family crisis of alcoholism. Some families pass through all stages to a happy ending while others traverse only part of the route. Families also vary as to the length of time spent in any one stage. At first a family denies the existence of the problem and tries to retain intact the family's organization and role expectations, despite recurrent disruptions due to drinking. In the second stage the family makes frantic trial-and-error efforts to control the problem. The roles of family members are in a state of flux as an attempt is made to arrive at a division of labor which will make drinking unnecessary or impossible. Following this stage there is a downward slump in family organization. Roles are played with little enthusiasm. Relationships are progressively strained. Only minimal family functions are fulfilled. Finally, as some adaptive behavior is successful for the non-alcoholic segment of the family, reorganization commences and the family's structure is restabilized at a new level which cannot be disrupted by continuing alcoholism. Should the alcoholic recover, however, a new crisis is engendered and a still different type of family organization must be evolved.

At each of these characteristic stages roles are reshuffled among family members, changes occur in intra- and extra-family status and prestige; "self" and "other" images are restructured; and the degree and type of family integration, self-sufficiency and solidarity are altered. The family as a unit and the individual members tend to become progressively more isolated until the reorganization phase.

The alcoholic is isolated most of all, even after the family has moved in the direction of reintegration.

As alcoholism progresses, the status of the alcoholic in his family is steadily downgraded. Initially efforts are made to help him retain his position as father and husband and his status in relation to the community. While inappropriate drinking is still sporadic each incident is treated as an isolated unit of behavior. Husband and wife examine their relationship and the family organization in an effort to understand the causes of the incident. Family roles, routines and associations which are hypothesized as contributory are altered for a short time until the anxiety associated with the inappropriate drinking incident diminishes.

With each renewed drinking episode this process is repeated. The family members cover up for the alcoholic among themselves and outsiders. Excuses are made for his behavior; it is reinterpreted as normal; and the family begins to cut itself off from community situations in which it might become visible.

As the behavior continues with greater frequency and greater disruptive effects on the family routines, organization and functions, it is no longer possible to maintain the role expectations of father. The discrepancy between actual role performance and expected role performance is so great that the family must take some action to survive. Trial-and-error behavior in structuring the alcoholic's role and status begins and family members become preoccupied with this problem. Within a short period he is treated as an invalid, a sinner, an irresponsible adolescent, a child, a full adult male, a distant relative, a stranger, a criminal and a madman. The family, in turn, reshuffles the social distances between members with rapidity. The effort seems to be to find the right combination for controlling father's behavior. During this stage almost no stable elements of family organization exist. Even the roles of children alter drastically. Probably the most obvious role of the father at this point is that of "major problem."

As none of these experiments proves effective morale deteriorates and disintegration sets in. Purposeful behavior is replaced by sheer survival actions; roles are played with little or no enthuiasm; family routines are not re-established; family functions are not fulfilled or are delegated to community agencies. Behavior is engaged in because it is tension-relieving rather than an aspect of an integrated role. Family members go their own ways. Insofar as it is possible to think of father as having a status in such a disorganized social group, he is "a bother."

In earlier stages his periods of prolonged sobriety mobilized the family towards reorganization. At this point sobriety gained with help from treatment agencies can still stimulate a rise in family morale and an attempt to come together again. At such times attempts are made to restore the family's original status structure.

As other crises multiply and drinking continues, now accompanied by other socially unacceptable behavior, there usually comes a point at which the wife is jolted enough to resume her role as mother and, gradually, to assume the roles of her husband. Family routines are re-established. She assumes authority over her husband and children and family life becomes structured. The children begin to play their roles within and outside the family with improved morale. Family relationships with the community are reestablished and the family stabilizes with the mother at the head. The father's

status in the eyes of the whole family is that of the most recalcitrant child. The main attitude towards him is exasperation. The non-alcoholic segment of the family becomes a community status-seeking unit apart from and despite him.

After the reorganization, if the alcoholic fights against his low status or proves disruptive to family organization and functions, which is often the case, it is only a short step to his removal from the family. This may occur either through divorce or desertion.

Unfortunately, the last family crisis of alcoholism occurs only occasionally. If the alcoholic recovers and maintains his recovery for a time, the family may re-include him. Reorganization to restore him to his major family roles is often painful to family members who must relinquish aspects of their own roles to make a place for him again. After years of believing that if father became sober all problems would evaporate immediately, it is difficult for the alcoholic and his family to accept that reorganization of mutual expectations in line with the new realities, against a background of their experiences with each other, can evolve only slowly over a long period of time. For some years after recovery and after the resumption of full participant in his family, the alcoholi holds his high status and is permitted t exercise his roles only on probatio Whereas recovery of the alcoholic ma begin suddenly, the full reorganization the family as a successfully functionin unit is a process which is prolonged.

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Psychiatric treatment of offenders

Today's problem of crime and juvenile delinquency is enormous. In 1951, J. Edgar Hoover estimated that crime costs the United States at least $15,000,000,000 a year. Today the cost would be closer to $20,000,000,000. These figures do not include an estimate of the cost in human misery and in productivity of almost 1,500,000 lost human beings, half of them children under 16.

The experience of the Association for Psychiatric Treatment of Offenders[1] has led to the conclusion that at least 25% of all offenders would benefit from psychotherapy administered as an adjunct to, but not as a substitute for, existing legal procedures. The program of APTO is geared to utilize the authoritative role of the court and of probation and parole services while the therapist attempts, through an educative or reeducative process, to help the individual to direct his energies into socially acceptable patterns.

This experience led to the conclusion that a program for treating selected offenders in a community setting offers great promise. Besides being a hopeful answer to the problem of recidivism of the rapidly increasing number of lawbreakers, therapy in the community is more humane and less costly. The extra-institutional therapy of APTO, for example, can treat six offenders for the $2,500 yearly maintenance of a single inmate in a standard penal institution.

GOALS OF THERAPY

The first goal of therapy is the cessation of law-breaking activities. This goal is put

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[1] A non-profit organization founded in 1950 to afford psychiatrically-oriented treatment of offenders.

first for the very practical reason that unless these activities are curbed the patient, of course, cannot be permitted to continue therapy as a free individual and must be removed from the community to protect society. Naturally the therapist cannot and should not act as a policeman; however, he should coordinate his efforts closely with those of the probation officer, either directly or through APTO's set-up, especially in the first phases of treatment. This demand on the therapist is unique to APTO's system and requires that the therapist forego some of his traditional detachment. Neither the psychotherapist in ordinary private practice nor the therapist treating offenders in an institution must face this problem, for the former rarely treats a convicted offender whose activities may constitute a real threat to the community and the latter has to worry little about crimes his patient may commit while in the controlled environment of an institution.

For another reason, also, close cooperation between therapist and probation officer is essential in the first phases of treatment. The offender is rarely a willing patient. Often it is necessary for the probation worker to bring the patient to his first appointments, or the therapist may have to inform the probation worker that the patient is not showing up for appointments and enlist his aid in getting the patient to return. As therapy proceeds the patient should develop a willingness to see the therapist of his own volition. In fact, the development of motivation for treatment is one of the first indications that therapy is progressing satisfactorily.

The second goal is socialization, that is, the offender must become adjusted, or readjusted as the case may be, to the restraints and demands of living in a community. This process involves, as a minimum, the establishment of at least some social contacts, however tenuous they may be, and the getting and holding of a job. The reluctance to get jobs and to work steadily is one of the central difficulties with most offenders. This symptom can be effectively treated only when the offender is in the community and is faced squarely with the necessity of applying for jobs and earning a living.

When these first two goals are achieved the patient is no longer an offender and becomes much like the patients seen by psychotherapists engaged in the usual office or clinic practice. Therefore, the third goal of therapy is the same as for non-offenders undergoing psychotherapy—the readjustment of the individual's personality to allow him to live in harmony with his culture and to enable him to be a useful and productive citizen.

In discussing the goals of therapy, the advantages of treatment in the community rather than in an institution have been touched upon; however, this matter is important enough to warrant further emphasis. Psychotherapy of an offender in an institution is, at best, highly artificial. The pressures and demands on him as an inmate of an institution are entirely different from those of a community. Even if he becomes well adjusted while in an institution, he is totally unprepared for the stress and strain of life outside. This one factor may well explain why efforts at psychotherapy in institutions have often been so disappointing, for whatever adjustment is achieved may break down soon after the offender is released. Furthermore, APTO believes that its system of treatment, taking place in the therapist's regular office rather than in a special setting or clinic for offenders, is an important factor in achieving rehabilitation.

Whether only the first goal, the first two goals or complete rehabilitation can be

achieved depends, of course, not only on the therapist's skill but also on the raw material with which the therapist must work and the support he can get from the patient's family and social milieu. Complete rehabilitation is not always possible, but it is always to be attempted.

RESULTS OF THERAPY

The following are three case histories from the files of APTO which illustrate the problems of treating offenders and the rewards which can sometimes be obtained.

Curley, age 27, was a gangster and holdup man. He had a long record of 20 previous convictions for a variety of offenses, had spent two years in a reformatory and six and a half years in prison, and had been paroled for another 13 years. The patient was sent for treatment by a lawyer and was one of the few who came without outside pressure, though his long parole had a strong influence on him.

The patient was of superior intelligence and was intellectually interested in psychoanalysis. The fact that the therapist treated him on a level of intellectual quality made for easy conversation; and that he could have friendly contact with a professional, law-abiding person was important to him, as he had no friends. His intellectual interest was largely a rationalization for the fact that he needed help against a severe depression, feelings of depersonalization and tendency to drink.

Although the therapist gave some interpretations, she was careful to phrase them so that they did not evoke anxiety. It was always kept in mind that the main aim of therapy was to socialize the patient and stop any upheaval that might lead to uncontrollable antisocial acts, which in his case would have meant a very long prison sentence, and not just to elicit interesting material. The treatment lasted about 60 sessions, over 9 months, and irregular contact was maintained over several years.

Follow-up (9 years): The patient is married, has several children, has worked steadily and lives a law-abiding life.

Lefty, age 13, was arrested several times for larceny and burglary and had a long record of delinquency. He had been treated unsuccessfully for two years elsewhere. He was referred to APTO as an alternative to immediate institutionalization, which had been recommended. The patient came unwillingly, accompanied by his mother. He was sullen and suspicious and remained silent throughout the whole interview.

The therapist's first task was to establish rapport. He did this by getting the boy's interest by discussing delinquent activities and by giving him the feeling that he might protect him against being sent away. He succeeded in that the boy came the second time on his own, but was uncommunicative. Slowly a relation was established by taking him out of the office for walks and to restaurants and movies, and by helping him with his innumerable difficulties.

Lefty had an unusually unfortunate home life. His mother was widowed, a thoroughly unhappy, embittered and hopeless woman. His brother was mentally defective and was living on relief. The therapist visited the patient occasionally at home and established some relation with the mother.

Gradually he succeeded in developing a genuine and deep attachment in the boy and in stopping his law-breaking activities. He helped him to get some part-time jobs but found no solution for the home situation. Lefty had about a year of regular treatment, and after that for several years maintained occasional friendly contacts.

Follow-up (6 years): He is now almost 20, has a girl, leads a normal life, and has worked for several years very satisfactorily.

Mary, age 23, narrowly escaped being sent to prison for persistent shoplifting. She was put on probation for three years, with the condition of making $3,000 restitution, and was sent to APTO by her probation officer, who thought her in need of psychiatric care.

She was a good-looking girl with some education and personality. Her mother had died when she was a child and she was brought up by a stepmother with whom she got on badly. She married young to get away from home, but her husband turned out to be a homosexual who gradually deteriorated into becoming a homosexual prostitute. Mary started to drift, to take up with undesirable men, and to shoplift after her husband deserted her. When she came for treatment she was living with her child, who had become very difficult as a result of neglect. The father, stepmother and a younger brother also lived in the same cramped quarters under a great deal of strain, but there was no alternative to this living arrangement.

The therapist first tried to improve the immediate family situation, talked to the father and gave some help concerning the child. There was close cooperation between the probation officer and therapist. Mary slowly worked out her problems in a modified analytic therapy and began to settle down to normal life. She started seeing a young man who came from a very bad home background, had a criminal record, and was uncultured, but had certain good qualities. Mary's therapist also saw her boyfriend for a few therapeutic interviews and gave him some confidence and initiative. Mary's treatment lasted about six months, sessions being held once a week. She stopped when she was engaged to get married, but saw the therapist a few times later to keep in touch.

Follow-up (3 years): Both Mary and her husband are working, and the child has become more normal as the family situation has straightened out.

Of course, the outcome is not always as favorable as in these cases, but as more is learned of the basic psychology of the offender and as therapists become more experienced and skillful a higher percentage of salvage for useful life can be expected. These cases also illustrate the way APTO therapists work with the courts and probation personnel and how they achieve the three goals of therapy.

WHAT APTO CAN AND CANNOT DO

The APTO cannot solve the problem of delinquency by itself. However, it can mobilize the therapeutic resources of the New York area, and the local chapter of APTO can serve as a prototype for similar organizations in other large cities. In addition to making available to the community the skills of those therapists who have some experience with offenders but who are now in private practice and rarely, if ever, treat offenders, APTO can stimulate the interest of other therapists in seeing such patients and can train them in the necessary special techniques.

The research efforts of APTO are most important because so many offenders who are obviously in need of psychiatric treatment do not respond to or benefit from the usual psychiatric approaches. The APTO has for years studied methods of making unwilling patients amenable to treatment. We have already demonstrated, on a small scale, that this can be done, but it is essential to experiment further with yet other types of patients and to develop further approaches. Also, it is necessary to demonstrate to psychotherapists and to the public

on a more comprehensive scale that many offenders previously regarded as not amenable to therapy can be successfully treated.

At present only a small number of therapists are employed full- or part-time by the New York City courts and correctional institutions, and they are faced with an overwhelming case load. These therapists, with so many demands on them, often can make only diagnostic reports, because not enough time is available for actual treatment. Moreover, many of the patients who are seen cannot receive the individual attention necessary. The APTO can, by mobilizing experienced therapists who are now in private practice, greatly increase the number of patients treated, giving them and their families the full individual attention they need. Still more important, it can, by its training program, provide a constantly increasing pool of trained personnel to draw upon.

The greatest hope that psychotherapy offers is that it will reduce recidivism, in which respect our present methods of correction have largely failed. A serious offender, before his career is finished by death, costs the community hundreds of thousands of dollars to apprehend, bring to trial, and maintain in prison for his repeated crimes. Surely, even when considered only in terms of dollars and cents, ignoring the more human values on which one cannot put a price tag, all logic dictates that we must try a more modern solution to the ever-increasing problem of crime when our conventional methods prove inadequate. Moreover, now is the time to begin this experiment, which promises so much at so little cost.

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Establishment and maintenance of a mental health unit

A case history and general principles

The mental health specialist has acquired considerable importance in our society in recent years, first as a therapist and more recently as a consultant. Traditionally located in an office in private practice or in a social agency or clinic, he has moved out into a variety of settings and has taken on a range of responsibilities. While the public and professional groups such as teachers, nurses and welfare workers have come to accept the mental health specialist and to seek his services, there continues a certain amount of fear of and resistance to him. Increasingly, however, education and health departments are turning to these specialists for mental health services. From the standpoint of the specialist, the following questions arise: How should he become involved? What steps should be taken in introducing and maintaining a program in such settings? What kind of program should be established? What relationships are involved? How can the service be maintained? Very little has been written on this subject, mainly because there has been so little experience.

At the time they wrote this article, the authors were on the staff of the family guidance center at the Harvard School of Public Health. Dr. Hamovitch, a social worker, was on a year's leave of absence as professor of research in the University of Southern California's school of social work. Dr. Caplan, a psychiatrist, directs the family guidance center and is associate professor and head of the mental health program in the department of public health practice at Harvard. Dr. Hare, a sociologist, is in Harvard's department of social relations, and Miss Owens is the center's public mental health nurse.

Their paper, on the origins and establishment of a mental health unit, is the first in a contemplated series of three.

The purpose of this paper is to report on one such experience and to attempt to derive principles which may be helpful to others embarking upon similar undertakings. While it must be kept in mind throughout that the paper is based on one "case," we hope it has relevance to other groups, in other settings.

First, perhaps, it would be well to define some terms. *Mental health specialists* as used in this paper refers to psychiatrists, psychologists, social workers and mental health nurses. The "case" used as the basis for analysis refers to a mental health unit established under the auspices of a school of public health in a district office of an urban health department. This unit has been in operation for four years. Throughout its history it has had a dual function: (1) to demonstrate the feasibility of providing mental health consultation to public health nurses and to study the nature and purpose of the consultation; and (2) to study the impact of selected crises on the mental health of families.

ORIGIN OF REQUEST FOR PROGRAM

The antecedents of this particular project had their origin in an operating field training unit of a School of Public Health, located in a district office of an urban health department. At one time, an attempt had been made to set up a mental health unit that would provide direct services to patients as part of the training unit. This attempt was not successful, and at the time our story begins the director of the training unit was eager to reactivate some kind of mental health program. At the same time, the directors of a large foundation were interested in encouraging the development of community mental health programs and had approached the school with the idea of possibly providing a grant to develop a plan. As a result, the school's division of mental health was asked to survey the situation, to advise on the feasibility of setting up a unit, and to recommend the program best suited to the situation. The forces behind the idea, therefore, were favorable.

A first principle may be noted here which, while not startlingly original, is worth reporting. A new program has much more chance of being accepted and utilized if the original idea comes from those who must have something to do with its administration and financing. Many instances can be cited where programs have failed, or certainly were made more difficult of achievement, because the initial motivation came from the mental health specialists, wanting to move into a situation and having the task of convincing people that the program was desirable. Under these circumstances there is apt to be an air of suspicion that the "experts" are trying to force something on a group on the notion that "we know what is best for you" or "please let us show you what we can do." Either way, the host agency is apt to be suspicious of and somewhat resistant towards the incoming group.

In this project the request came from "within" to a larger extent than is sometimes possible, putting the mental health specialist in a much more favorable position—that of invited guest rather than self-invited intruder.

THE INITIAL PHASE

The psychiatrist on the faculty of the school who was asked to come into the picture was careful from the outset to make it clear that he did not view the invitation as a commitment by either side. This reflects a second principle, namely, that an invitation to explore the possibility of introducing a new program should not be

construed as a firm commitment to implement any suggested program. Too often, experts who have been invited on a tentative basis have misconstrued the invitation as an endorsement, and have taken over—like "The Man Who Came to Dinner"—in such a breezy, authoritative manner as to frighten the hosts. It is just this practice which has made laymen in social agencies wary of "experts."

In the case being presented the first approach was to obtain as much information about the situation as possible, and at the same time to seek sanction from key figures for any project that might be developed. As quickly as possible the psychiatrist established contact with all the key figures as he was able to determine who they were. The field training unit was located in a health unit shared by a number of agencies, including health department nurses, visiting nurses, a well-baby clinic, a dental clinic, a communicable disease clinic, sanitary engineers and a day nursery. All were possible units with which to work. The mental health specialist conferred with the key people in each of these groups and also with the line personnel, to learn what they were doing and the extent and nature of their possible interest in a mental health program. He also conferred with community leaders, such as the priest in one of the local parochial schools, to determine their receptivity to a mental health program.

A couple of principles must be kept in mind here. A newcomer to any area or program should, as quickly as possible, make himself known by and should get to know the community with which he wishes to work. Otherwise, some will feel they have been slighted by not being approached early, and may develop fantasies about the "stranger." This is important, because sanction must be sought not only from the group eventually served directly but from others who may possess the power to sabotage the best laid-out program if they are opposed to it. Seeing everyone quickly is a means of dissipating any stereotype individuals or groups might have of a "psychiatrist." If they could see him, alive and human rather than sinister and evil, they might not be prey to fantasy as are many laymen regarding psychiatry. Therefore, they might be more ready to accept and even to utilize his services.

Another important principle underlying this activity is that the newcomer to a situation unless he orients himself thoroughly, may perceive only a portion of the problem and may possibly develop a distorted picture of it, leading to unwise decisions.

This, then, was an information-seeking, sanction-seeking, fantasy-allaying phase of the operation. One of the problems was to determine who were the key figures who should be seen and whose sanction was important. In this, the psychiatrist did very well with one exception—and the exception later nearly proved the undoing of the project before it could even get underway. This will be discussed a little later in the paper.

A further principle operating here was that the psychiatrist did not come with a preconceived plan which he was to execute by manipulating people and circumstances. He really had an open mind about the feasibility of a program and about its nature. His information-seeking, therefore, was not just a mechanical, going-through-the-motions type of operation; it was a genuine seeking for pertinent information. Too often in social planning we "pretend" we want help from community people, when we really are giving them the illusion of being helpful to us so that they can be persuaded to do our bidding—the "hidden agenda" idea.

In the case being reported in this paper the psychiatrist believed some kind of program might be desirable and he had some notions about different kinds of programs which might be appropriate; otherwise, there would have been no point in getting involved at all. But he had a sufficiently open mind about it so that the decision might be, at this point, that it would not be feasible or that another approach might be better than the one first thought of. Furthermore, there was no thought of "selling" a program. Selling might be all right under certain circumstances, but it did not seem appropriate here. As he talked to key people, the mental health worker made it abundantly clear on every possible occasion that he subscribed to the principle that any feasible plan must fit into the existing organizational and administrative structure of the unit and must interfere as little as possible with current activities. On the one hand this helped to counteract the interviewees' natural suspicion of an investigator who might write a critical report, and on the other it allowed him to focus the interview on a detailed appraisal of the organization of the daily work.

Another point which should be mentioned here is that the psychiatrist, in seeking sanction, conferred with the administrative heads of the health department in addition to the administrators of the local district office. From the former he sought global sanction, however, rather than approval of details. In other words, it was not necessary to obtain specific sanction for this project, because this was implied in the sanction that had already been given to the training unit. But a verbal kind of interaction was necessary to let the central administration see the mental health specialist and know first-hand that he was on the scene and involved in a program already approved. Detailed sanction was sought at the local level on the details of the plan.

The principle here is that in negotiating contracts for new programs detailed sanction is necessary at the local or line level, with less detailed and more global sanction necessary at more central or higher echelons.

DEVELOPMENT OF A PLAN

In the course of the appraisal phase the psychiatrist had to decide which of the various possible goals for a mental health program in this setting appeared both valuable and practicable. The initial invitation from the field training unit had been quite vague as to goals. From the unit's point of view, the program should fit into the ongoing activities of the building in which it was located; it should be in line with the goals and philosophy of the School of Public Health (that is, it should embody the latest ideas on the control and prevention of illness and the promotion of health); it should afford opportunities for research and the teaching of students; and if possible it should be in line with the ambitions of the field training unit to improve the operations of the city health department as a whole.

The psychiatrist believed also, however, that any program should interest itself not only in the activities of the city health department staff in the building; but also in the activities of other agencies there and in the forces influencing the mental health of the community outside the sphere of operation of these units. This was in line with general community organization principles. However, it appeared very quickly that there was no single community in which this district office was located, but rather a whole series of communities with varying interests and focuses. It became obvious, too, that if the mental health

specialists attempted to establish relationships with all the different groups in the community the major portion of their time would be spent with groups other than the one being served directly. This did not seem feasible.

It was also clear that a number of the agencies in the community offered some kind of mental health services. To introduce a new program to compete with these would be to encroach on their activities and to increase the defensiveness of their personnel. It appeared, therefore, that we would be wiser to narrow the focus of the new program to the operations within the district health office building and to deal with external community affairs and issues only within this context. Since the Visiting Nurse Association already had its own mental health program, this narrowed the focus still further to the city health department staff. Of the latter, the public health nurses seemed the most interested in a new program. Strategically they were in the best position to provide information about people in emotional difficulties because they visited families in their homes during times of trouble. This therefore seemed the group upon which the program might initially best be focused. This primary focus was accepted only as an initial approach, however, and the way was left open for working with the psysicians, dentists and sanitarians, if in the process of time they might be interested in collaborating in the program. Contact with other agencies in the building or outside was to be incorporated in the program only insofar as it facilitated collaboration with the health workers, and was not to be undertaken merely because it promised benefit to the mental health of residents in the area.

Two principles seemed to be somewhat in conflict here:

• Any new program should be concerne not only with an immediate group to b served but also with the wider communit This is in line with a point made earlie that a mental health program particularl needs to keep in mind the peripheral powe groups, and perhaps has an obligation t involve them in an educational program.

• Another equally important principl however, holds that if a new program i to be effective with any one group, activit must center on the group and not b diluted in efforts to spread availabl resources too widely. Furthermore, i selecting a group with which to work i is wise to choose first the group most willin to cooperate in a project.

In this instance it was decided that th second principle applied, and so the dec sion reported above was made.

It is worth noting further that the Visi ing Nurse Association requested menta health consultation, but the psychiatris decided against acceding to this reques This was done on the grounds of refusin to compete with an already existing servic He was thus making clear that he was no planning a spreading empire. To hav accepted would have strengthened th stereotype of this "dangerous person, ready to reach out his tentacles to embrac anything that was available. Too ofte we become seduced by these requests fo service when, in fact, they may be a mean of testing the degree of our acquisitiveness

The next question to answer was wha would be the type and purpose of a menta health program which might be worked ou in collaboration with the nurses. Finding so far indicated that the latter had con tact with patients suffering from differen gradations of emotional disturbance, tha they had considerable experience in iden tifying at least the most obvious of thes

conditions, and that they had some skill in handling them in their everyday work, either by some form of counseling or advice or by referral to specialist psychiatric or social work agencies. The program might thus have the goal of collaboration with the nurses for the secondary preventive purpose of early case-finding in order to provide screening, diagnosis and either treatment or referral; or it might aim at some type of primary prevention in the identifying of maladaptive responses to life's difficulties which were predictive of future psychiatric illness, and the instituting in such cases either of preventive intervention by psychiatric workers or of counseling and mental health promotional help by the nurses themselves under the guidance of psychiatric consultants. In both types of programs the alternatives seemed to be to use psychiatric specialists for direct work with patients identified and referred by the nurses or to use the specialists to influence the patients indirectly by helping the nurses deal more perceptively and skillfully with their problems.

A review of these suggestions, however, revealed that some aspects were in conflict with certain important forces which seemed to be operating in the nurses' culture. The most significant of these appeared to be the reluctance or ambivalence manifested by the nurses in referring any but the most disturbed cases to outside treatment and resources and even to the social worker in the building. It should be possible for a remedial psychiatric agency in the building to accept cases from the nurses and to treat them without taking the family from the referring nurse; but in practice this might prove difficult, and in any case, especially at the beginning of a new program, rivalrous fantasies might develop, to the detriment of the relationship between the two groups.

It was clear that the nurturing and safeguarding of good relationships between the mental health workers and the nurses must be the fundamental goal of any program which wished to operate in the partnership and to survive. It seemed, therefore, that in the initial stages at least the program should not include a treatment clinic which involved removing a nurse's patients from her traditional professional life space to a psychiatrist's office, from which the nurse would be excluded. Further support for this was provided by the idea that if relationships between the nurses and the mental health worker ran into difficulties, which was quite a likely possibility, and if these difficulties focused upon the management of a patient for whom the mental health workers had professional responsibility as a treatment case, they would not be as free as they might otherwise like to be to cater to the nurse's difficulties and to be guided by her felt needs of the moment, since they would have to focus primarily on the needs of their patient.

It was believed that interaction between the two groups of workers must be the basis for building a partnership. The idea emerged, therefore, that in order to build this partnership with maximum security and with least difficulty a program should be planned which would allow the rate of interaction and the content of communications between the two groups to be constantly adjusted to the current attitudes of the nurses. In other words, the program should develop at a rate which could be tailored to the growth of the emotional bonds between the nurses and the mental health workers, and to the nurses' increasing interests and insights in mental health matters. Moreover, the content of the interactions should be chosen in such a way that it should interest the nurses and yet should not arouse resistance and defensiveness either because it would be too un-

familiar or because it would be emotionally more burdensome than they could easily cope with at that stage. A program fundamentally designed to avoid arousing resistance must, however, avoid the other big danger—namely, of reducing interactions to a minimum by discussing only pleasant, interesting, harmless topics, which would result in the building up of friendly relationships of a social nature between the two groups but not a useful working partnership to achieve serious and profitable goals.

A principle was followed here which is frequently overlooked in planning new programs. Too often we adhere to sound practice in establishing the proper relationships, in learning about the community and the group we wish to serve, in keeping channels of communication open, and so arrive at a sound decision that a program would be acceptable and feasible—only to fail to see ahead and prepare for possible future complications. Here it was apparent that the nurses would accept a mental health program now; but what of the future? Our knowledge of the nurses' culture would seem to foretell that eventually there might be problems and that it would be wise to set up a program which could survive these problems, rather than assume that acceptance now would mean acceptance in the future.

From these considerations the outlines of a plan began to take shape. Instead of using the referral of patients for psychotherapy as a vehicle for collaboration, we might find it possible to stimulate the requisite rate of interactions of appropriate content by involving the nurses and the mental health workers in the planning and execution of some sort of study. The content could be chosen so that it dealt with issues which interested the nurses and yet did not particularly disturb them, and which also interested the mental health workers. If possible, the study should be so formulated that it dealt with certain of the nurses's patients, but the choice of patients to be investigated should be a very simple matter as far as the nurses would be concerned. The study should require that the nurses continue to treat patients as before, and if possible it should not involve any therapeutic service for the patients by the mental health workers. Since different members of the nurses' group would vary in their readiness to collaborate and since at any particular time some nurses might feel temporarily negative in their relationships with the mental health group, the study design should, if possible, be flexible enough so that cases could be chosen from such districts and in such numbers that only the currently receptive nurses need be involved; or if a nurse in a negative phase were to be asked to collaborate, this should be by design in relation to her attitudes and not be dictated by the needs of the research.

Finally, this joint study should be used as a departure point for any other collaborative endeavors in the mental health field for which the nurse might from time to time express a need. The door could always be left open for consultation with specialists about any of the nurses' daily work problems of mental health significance, and eventually the collaboration might move on to the utilization of the mental health workers for direct preventive service to patients, once a stable, unambivalent working partnership had been consolidated.

FORMULATION OF A PROPOSAL AND SECURING OF NECESSARY SANCTION

Having decided tentatively on a plan, we had next to get reactions to it from those key people whose sanction was important to the operation of any plan. First, clear-

ance was obtained from the head of the Division of Mental Health. Next to be approached were the directors of the field training unit, who had extended the invitation initially. Then to be involved was the head of the Department of Public Health Practice of the school. All of these individuals agreed with the general plan presented. It was agreed further that the program should be independent of the field training unit, to allow for development at its own pace. Out of this grew the idea for a special grant from the foundation which had encouraged the establishment of such a program.

Before proceeding to form a proposal, informal talks were held first with the supervisor and assistant supervisor of nurses to discuss possible study areas. Then all the nurses in the center were called together to hear the tentative proposal.

This was in accord with an important principle—of involving line workers actively in any new proposal before final decisions are made rather than presenting them with a *fait accompli*. Too often, again, we do well in involving appropriate personnel in the planning of a program, but when we have arrived at some tentative conclusions we go ahead with them in final form without checking back with these people to get their reactions and without being prepared to modify our proposals before putting them into operation. The nurses were clearly impressed with the fact that the psychiatrist had fulfilled his promise on this point and a much more trusting atmosphere was established than would otherwise have been the case. We also reported back to other groups which had been approached for ideas, to assure their friendliness toward the project even though they would not be directly involved in the operation.

Much of the work of obtaining sanction for the plan from the various individuals and groups whose approval was necessary for its acceptance had already been accomplished by involving them actively in its details, so that by the time the project was committed to paper they felt a personel investment in it. This process had been consolidated by reporting back to them, which gave them an opportunity to think through in a concrete manner how the program would affect their interests and to suggest modifications in those details which they felt might not fit too well into their existing activities. Such sanction as had been obtained in this way was, however, of an informal nature, which meant that it did not specifically commit the individual or the group to the support of the program, and it was important that a formal act of sanction should be explicitly undertaken to accomplish this. It was therefore necessary at this stage to approach each of the authority groups involved and formally request their approval of the proposed program.

It was in thinking about these authority groups that the psychiatrist ran into the trouble hinted at earlier. One key authority in an allied area was not approached in the course of these negotiations because his relevance and the relevance of his institution to the project were not clear. It turned out, however, that this person was an important community leader whose opinion was now solicited in regard to the acceptability of the new program. Because he had not been involved earlier, he knew little about the proposal and was somewhat bewildered because he had not been consulted from the outset. Behind the scenes he raised some serious questions about the project and its director. This delayed formal approval of the project for some time, and in fact for a while the fate of the project was in considerable doubt. The dif-

ficulty was overcome finally, and the extra clarification led eventually to the building up of firm collaborative relationships between the institution and the project. But the experience demonstrated the principle that it is important to identify and involve all of the key people directly or indirectly related to a proposal, if a proposal is to have all the necessary sanction for its success.

THE PLAN

The final program as presented to the foundation for approval, and which was approved, consisted of the following possibilities:

- Consultation with members of the health unit staff on mental health problems in any area of their work, to advise on practical policy in any particular case and to increase a staff member's knowledge of mental health implications and mental health techniques.

- Training of staff members of the health department by systematic courses of group instruction.

- Study of emotional problems of selected families in the area, to work out techniques for preventing emotional disorders. Such techniques were to include both those suitable for mental health workers and also for public health workers. In this study the public health workers, in particular the nurses, were to be involved in order to give them an opportunity to participate in an active learning process.

- Teaching of students of the School of Public Health and the Medical School.

The staff proposed for the project was to include a half-time psychiatric director, a psychiatric consultant, a full-time psychiatrist, a social casework consultant, a mental health consultant nurse and two full-time secretaries. Liaison was to be established with a number of agencies and other projects. These included a mental hospital discharge study, a human relations service, appropriate people in the School of Public Health, and other agencies within the building.

From the outset it appeared that the project had two major functions: to provide a consultation service to the nurses and to undertake research. These were seen as complementary, but it was recognized from the start that there might be some conflict between the two. Research was to have a place of its own and was to stand on its own merits; at the same time, it was to be used as a device for establishing proximity with the nurses so that consultation could be encouraged and facilitated. Wherever the research interfered with the establishment and maintenance of relationships between the mental health workers and the nurses, however, it was felt that the service aspect should take precedence and the research should be modified to reduce the interference as much as possible. This became somewhat of a problem throughout, and is probably inherent in any situation where research and service are so closely interrelated. However, it should be noted that the problem is primarily one for the workers involved rather than for one deterring the success of either aspect of the project. While the caliber of the service and the research might be affected, perhaps even more serious was the possibility of role conflict for the workers involved.

SUMMARY

In this paper an attempt has been made to look at a case history of the establishment of a mental health unit in order to note

certain principles which might have relevance for others contemplating similar undertakings. The material was based on one case only, and the principles which emerged are not necessarily original or dramatic. However, it was possible to identify and illustrate what seemed to be a number of sound procedures in the establishment of a mental health unit. It is hoped that these will be of some value to others contemplating similar undertakings in other settings.

A LITANY FOR SICK SOULS

To those who limp among us,
Speaking our common tongue, and only half suspecting
The meaning's different:
For when they say *love* they never felt it theirs
And never having it, they cannot give it . . .
To those puzzled, perverse souls
Dear Lord, Bring Healing!

To those who dam themselves a pool
Away from Thy living tides,
A pool for ever-same and ever-self reflecting . . .
To stagnant, slime-choked souls
Dear Lord, Bring Healing!

To those who hide themselves
From Thy common blessing light of day
In caves where only one may huddle,
And each must paint his devil on the wall
To quake before . . .
To Those, Dear Lord, Bring Healing!

To those who cannot freely move
Through opening gates of paradox which mark Thy realm—
Those who forever hammer at their brain-walls
Demanding Thy reason; losing theirs
In echoes they mistake for answers . . .
Dear Lord, To Those Bring Healing!

—HAZEL KUNO

BENJAMIN MALZBERG, PH.D.

Mental disease among Negroes

An analysis of first admissions in New York State, 1949-5

Scientific progress may be furthered by the discovery of differences in the mental health or illness of people that are related to the differences in conditions under which they live. . . . Anything that facilitates the exchange of knowledge about people and the way they live and behave may further the understanding of mental health in any one country.
—George S. Stevenson, M.D.*

According to the census of 1910 there were only 134,191 Negroes in New York State at that time; they made up 1.4% of the total population. The Negro population increased by almost 50% between 1910 and 1920. By 1920 they numbered 198,483 and made up 1.9% of the total population. far greater increase occurred during t next decade. The Negro population i cluded 412,814 in 1930, or 3.3% of the tot This was the period of the first great migr tion of Negroes from south to north, aft the first World War. Since 1930 the Neg population has continued its rapid increas It grew to 571,221 in 1940, or 4.2% of t total, and reached 919,679 in 1950, or 6.2 of the total. Thus, between 1910 and 19 the Negro population of New York Sta increased almost seven-fold, compared wi an increase of only 55% in the whi population.

As a result of these increases in the popu lation there were corresponding increas in the number of annual first admissio to the New York civil state hospitals. Th earliest data for Negroes are for 191 There were 202 Negro first admissions du

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* *Mental Health Planning for Social Action* (New York, McGraw-Hill Book Co., 1956), 317–18.

ing that year, or 126 per 100,000 estimated Negro population. By 1940 this had increased to 1,160 annual first admissions, or a rate of 203 per 100,000. During this same period the corresponding rates for the white population increased from 64 in 1914 to 92 in 1940.

Thus, over a period of 26 years the rates of first admissions to the New York civil state hospitals were substantially higher for Negroes than for whites. It is therefore of great interest to examine the data for 1950 to see whether the great increase in the Negro population was accompanied by significant changes in the trend of first admissions. Primarily because of low economic status there are very few Negro admissions to private hospitals for mental disease in New York State. However, there are a substantial number of admissions to these hospitals from the white population. Hence, it is necessary to make comparisons on the basis of admissions to *all* hospitals for mental disease.

This study consists, therefore, of first admissions to all mental hospitals in New York State from October 1, 1948 to September 30, 1951. The mid-point of this period, April 1, 1950, is the date of the census of population. In conjunction with the census we shall compute average annual rates of first admissions during this period for Negroes and whites in New York State.

Previous studies have shown striking differences in rates of hospitalized mental diseases among the white and Negro populations of New York State.[1] In the first place, there is a great numerical excess of such diseases among Negroes. This is true of all the numerically important groups of psychoses. It is especially significant, however, with respect to general paresis and alcoholic psychoses. In these groups of mental disorders, which are primarily of social and environmental origin, the annual rates of first admissions among Negroes exceed those of the white population in ratios of 6.7 to 1 and 3.8 to 1 respectively. There are further differences, such as the relative sex distributions of the rates. In general, differences between Negro males and females are relatively greater than those among whites.

In view of such important differences it is desirable to learn whether these trends continued during the decade 1940–50, and how they were influenced by the growth of population during that period.

During the three years from October 1, 1948 to September 30, 1951, inclusive, there were 6,167 Negro first admissions to all hospitals for mental disease in New York State. Of this total 2,789, or 45.2%, were diagnosed as dementia praecox. The second largest category, psychoses with cerebral arteriosclerosis, accounted for only 781 first admissions, or 12.7%. The alcoholic psychoses and general paresis followed in order of frequency. The former accounted for 534 first admissions, or 8.7%, the latter for 475 cases, or 7.7%. This distribution differs significantly from that of the previous decade.[2] During 1939–41 general paresis accounted for 14.8% of the Negro first admissions, the alcoholic psychoses for 11.3%. Together they accounted for 26.1% of the total, compared with 16.4% during 1949–51. Dementia praecox, on the other hand, increased from 29.2% of the total during 1939–41 to 45.2% in 1949–51.

The average annual rate was 223.5 per 100,000 Negro population. Dementia praecox presented the highest rate, 101.1 per 100,000. Other groups with significantly

[1] For example, "Mental Disease among Negroes in New York State, 1939–41," by Benjamin Malzberg, in *Mental Hygiene*, 37(July, 1953), 450–76.

[2] *Ibid.*

TABLE 1

Negro first admissions to all hospitals for mental disease in New York State, 1949–51, classified according to mental disorder

MENTAL DISORDERS	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
General paresis	313	162	475	9.8	5.4	7.7	24.8	10.8	17.2
With other syphilis of central nervous system	39	43	82	1.2	1.4	1.3	3.1	2.9	3.0
With epidemic encephalitis	4	–	4	0.1	–	0.1	0.3	–	0.1
With other infectious diseases	17	15	32	0.5	0.5	0.5	1.3	1.0	1.2
Alcoholic	365	169	534	11.5	5.7	8.7	28.9	11.3	19.4
Due to drugs or other exogenous poisons	10	5	15	0.3	0.2	0.2	0.8	0.3	0.5
Traumatic	45	10	55	1.4	0.3	0.9	3.6	0.7	2.0
With cerebral arteriosclerosis	362	419	781	11.4	14.1	12.7	28.6	28.0	28.3
With other disturbances of circulation	11	25	36	0.3	0.8	0.6	0.9	1.7	1.3
With convulsive disorders	83	47	130	2.6	1.6	2.1	6.6	3.1	4.7
Senile	99	203	302	3.1	6.8	4.9	7.8	13.6	10.9
Involutional	29	93	122	0.9	3.1	2.0	2.3	6.2	4.4
Due to other metabolic, etc., diseases	12	19	31	0.4	0.6	0.5	1.0	1.3	1.1
Due to new growth	5	5	10	0.2	0.2	0.2	0.4	0.3	0.4
With organic changes of nervous system	26	11	37	0.8	0.4	0.6	2.1	0.7	1.3
Manic-depressive	12	36	48	0.4	1.2	0.8	1.0	2.4	1.7
Dementia praecox	1,400	1,389	2,789	43.9	46.6	45.2	110.8	92.9	101.1
Paranoia and paranoid conditions	8	9	17	0.3	0.3	0.3	0.6	0.6	0.6
With psychopathic personality	118	87	205	3.7	2.9	3.3	9.3	5.8	7.4
With mental deficiency	96	96	192	3.0	3.2	3.1	7.6	6.4	7.0
Psychoneuroses	50	42	92	1.6	1.4	1.5	4.0	2.8	3.3
Undiagnosed	24	24	48	0.7	0.8	0.8	1.9	1.6	1.7
Without psychosis	22	18	40	0.7	0.6	0.6	1.7	1.2	1.5
Primary behavior disorders	38	52	90	1.2	1.8	1.4	3.0	3.5	3.3
TOTAL	3,188	2,979	6,167	100.0	100.0	100.0	252.3	199.2	223.5

high rates were psychoses with cerebral arteriosclerosis, 28.3; alcoholic psychoses, 19.4; general paresis, 17.2; and senile psychoses, 10.9. There were the usual sex differences. Males had higher rates of dementia praecox, alcoholic psychoses and general paresis. Females had higher rates of senile and involutional psychoses.

The relative distribution of the mental disorders was markedly different for the white population. Dementia praecox was again the leading category, but it accounted for only 26.9% of the total, compared with 45.2% for Negroes. Psychoses with cerebral arteriosclerosis and senile psychoses accounted for 19.4% and 13.9% respectively of the white first admissions, thus representing a third of the total, whereas these groups represented less than 20% of the Negro first admissions. On the other hand, the alcoholic psychoses accounted for 5.3% of white first admissions, compared with 8.7% for Negroes. The difference was especially marked in connection with general

TABLE 2

Negro first admissions to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
5–9	19	5	24	0.6	0.2	0.4	18.9	4.9	11.8
10–14	80	100	180	2.5	3.4	2.9	91.4	110.1	101.0
15–19	198	204	402	6.2	6.8	6.5	246.0	212.8	227.9
20–24	441	287	728	13.8	9.6	11.8	422.6	193.0	287.7
25–29	494	374	868	15.5	12.6	14.1	366.4	216.3	282.1
30–34	375	339	714	11.8	11.4	11.6	314.9	215.5	258.3
35–39	304	360	664	9.5	12.1	10.8	259.3	237.2	246.8
40–44	284	229	513	8.9	7.7	8.3	277.4	190.0	230.1
45–49	200	176	376	6.3	5.9	6.1	222.3	177.3	198.7
50–54	174	175	349	5.4	5.9	5.7	249.6	243.1	246.3
55–59	145	115	260	4.5	3.9	4.2	324.7	242.8	282.6
60–64	114	136	250	3.6	4.6	4.1	383.1	383.9	383.4
65–69	134	139	273	4.2	4.7	4.4	615.7	471.3	532.6
70–74	86	120	206	2.7	4.0	3.3	715.8	720.7	718.6
75–79	68	87	155	2.1	2.9	2.5	1,252.3	850.4	989.8
80–84	41	83	124	1.3	2.8	2.0	1,752.1	2,057.0	1,945.1
85 or over....	29	46	75	0.9	1.5	1.2	1,933.3	1,518.2	1,655.6
Unascertained	2	4	6	0.1	0.1	0.1	–	–	–
TOTAL	3,188	2,979	6,167	100.0	100.0	100.0	252.3	199.2	223.5

TABLE 3

White first admissions to all hospitals for mental disease in New York State, 1949–51, classified according to mental disorder

MENTAL DISORDERS	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 WHITE POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
General paresis	443	178	621	1.8	0.7	1.2	2.2	0.8	1.5
With other syphilis of central nervous system.	60	24	84	0.2	0.1	0.2	0.3	0.1	0.2
With epidemic encephalitis	43	40	83	0.2	0.2	0.2	0.2	0.2	0.2
With other infectious diseases	73	41	114	0.3	0.2	0.2	0.4	0.2	0.3
Alcoholic	2,139	578	2,717	8.6	2.2	5.3	10.5	2.7	6.5
Due to drugs or other exogenous poisons	68	129	197	0.3	0.4	0.4	0.3	0.6	0.4
Traumatic	256	41	297	1.0	0.2	0.6	1.3	0.2	0.7
With cerebral arteriosclerosis	5,135	4,799	9,934	20.7	18.1	19.4	25.2	22.6	23.9
With other disturbances of circulation	144	142	286	0.6	10.5	0.6	0.7	0.7	0.7
With convulsive disorders	315	247	562	1.3	0.9	1.1	1.5	1.2	1.4
Senile	2,684	4,456	7,140	10.8	16.8	13.9	13.2	21.0	17.2
Involutional	1,513	3,365	4,878	6.1	12.7	9.5	7.4	15.8	11.7
Due to other metabolic, etc., diseases	92	166	258	0.4	0.6	0.5	0.4	0.8	0.6
Due to new growth	133	119	252	0.5	0.4	0.4	0.7	0.6	0.6
With organic changes of nervous system	189	146	335	0.8	0.6	0.7	0.9	0.7	0.8
Manic-depressive	778	1,505	2,283	3.1	5.7	4.4	3.8	7.1	5.4
Dementia praecox	6,714	7,088	13,802	27.1	26.7	26.9	33.0	33.4	33.2
Paranoia and paranoid condition	149	128	277	0.6	0.4	0.5	0.7	0.6	0.7
With psychopathic personality	426	278	704	1.7	1.0	1.4	2.1	1.3	1.7
With mental deficiency	359	373	732	1.4	1.4	1.4	1.8	1.8	1.8
Psychoneuroses	1,442	2,030	3,472	5.8	7.7	6.8	7.1	9.6	8.3
Undiagnosed	178	103	281	0.7	0.4	0.5	0.9	0.4	0.7
Without psychosis	1,200	443	1,643	4.8	1.7	3.2	5.9	2.1	3.9
Primary behavior disorders	264	121	385	1.1	0.4	0.7	1.3	0.6	0.9
TOTAL	24,797	26,540	51,337	100.0	100.0	100.0	121.7	124.9	123.4

TABLE 4

Average annual rates of first admissions among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
under 10.....	7.9	2.1	5.0	5.1	3.4	4.3	1.54	0.62	1.16
10–14	91.4	110.1	101.0	33.6	20.2	26.7	2.72	5.45	3.78
15–19	246.0	212.8	227.9	173.8	141.8	156.6	1.42	1.50	1.46
20–24	422.6	193.0	287.7	298.3	151.9	208.3	1.42	1.27	1.38
25–29	366.4	216.3	282.1	291.2	188.4	230.0	1.26	1.14	1.23
30–34	314.9	215.5	258.3	331.0	209.5	262.7	0.95	1.03	0.98
35–39	259.3	237.2	246.8	291.5	207.4	245.9	0.89	1.14	1.00
40–44	277.4	190.0	230.1	308.2	202.0	254.4	0.90	0.94	0.90
45–49	222.3	177.3	198.7	389.5	263.2	325.8	0.57	0.67	0.61
50–54	249.6	243.1	246.3	460.1	250.3	352.5	0.54	0.97	0.70
55–59	324.7	242.8	282.6	454.9	372.1	412.0	0.71	0.65	0.69
60–64	383.1	383.9	383.4	588.5	477.6	530.5	0.65	0.80	0.72
65–69	615.7	471.3	532.6	883.7	677.8	766.7	0.70	0.70	0.69
70–74	715.8	720.7	718.6	1,208.0	749.2	937.5	0.59	0.96	0.77
75 or over....	1,488.7	1,248.9	1,332.6	1,644.6	1,685.9	1,671.1	0.91	0.74	0.80
TOTAL	252.3	199.2	223.5	272.8	193.2	229.6	0.92	1.03	0.97

paresis, which accounted for only 1.2% of the white first admissions, compared with 7.7% of the Negroes.

The average annual rate was 123.4 per 100,000 white population. Dementia praecox was most frequent, with an average annual rate of 33.2. Psychoses with cerebral arteriosclerosis, senile psychoses and involutional psychoses followed with average rates of 23.9, 17.2 and 11.7 respectively. Average rates for the alcoholic psychoses and general paresis were 6.5 and 1.5 respectively, both significantly lower than the corresponding rates for Negroes.

The differences between Negroes and whites thus appear to be of a quantitative rather than of a qualitative order—that is, the several groups of mental disorders all appear among both races, though in differing relative frequencies.

Between 1930 and 1940 there were marked increases in average annual rates of first admissions among Negroes. However, this was reversed in 1950. The general rate fell from 229.6 in 1940 to 223.5 in 1950. This was owing to a decrease among males from a rate of 272.8 in 1940 to 252.3 in 1950. The rate for females increased from 193.2 to 199.2.

Of greater significance, however, is the comparison by age (Table 4). Among males the average rates in 1950 exceeded those for 1940 through ages 25–29, though in decreas-

TABLE 5

Average annual rates of first admissions among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
under 10.....	3.7	0.7	2.2	3.9	1.4	2.7	0.94	0.50	0.81
10–14	17.6	11.4	14.6	9.8	5.9	7.9	1.80	1.93	1.84
15–19	82.6	73.1	77.8	55.8	46.4	51.2	1.48	1.58	1.52
20–24	141.9	96.9	118.3	96.7	76.6	86.4	1.47	1.27	1.37
25–29	128.4	114.6	121.2	102.4	97.6	99.9	1.25	1.17	1.21
30–34	105.8	118.6	112.5	114.2	104.5	109.2	0.93	1.13	1.03
35–39	105.6	118.9	112.5	123.5	115.4	119.4	0.86	1.03	0.94
40–44	109.1	124.2	116.8	131.1	111.7	121.4	0.83	1.11	0.96
45–49	113.6	132.3	123.0	134.3	127.3	130.9	0.84	1.04	0.94
50–54	127.4	135.2	131.4	154.9	141.7	148.5	0.82	0.95	0.88
55–59	144.2	143.0	143.6	164.5	142.4	153.7	0.88	1.00	0.93
60–64	184.6	159.9	172.3	207.1	172.4	189.4	0.89	0.93	0.91
65–69	255.3	209.4	231.2	269.9	229.6	248.8	0.94	0.91	0.93
70–74	386.4	363.3	373.9	361.0	310.9	334.2	1.07	1.17	1.12
75 or over....	797.8	792.8	795.0	665.7	584.4	620.0	1.20	1.36	1.28
TOTAL	121.7	124.9	123.4	115.4	105.3	110.3	1.05	1.19	1.12

ing ratios. Beyond age 30 the rates were all systematically lower in 1950. The trend was similar for females. Rates were higher in 1950 through ages 35–39, but the rates were all lower in 1950 beginning with ages 40–44. In general, the rates decreased more rapidly among females.

The trend was different for the white population, among whom the rate rose from 110.3 in 1940 to 123.4 in 1950 (Table 4). The increases occurred at the younger ages (under 35) and in old age (70 and over). Between these ages the rates decreased in amounts varying from 4% to 12%.

Among white males the rate increased during the decade by 20% at ages 10–14. The rates continued to grow, but at a decreasing ratio, through ages 25–29. The rates decreased at succeeding ages until advanced age, when they increased by 20%. Among females the rates increased at almost all ages during the decade.

Table 6 compares the average annual rates of first admissions among Negroes and whites at corresponding ages in 1950. Negroes had higher rates throughout. At younger ages the rates were in excess by over 100%. The ratios declined through ages 45–49, but increased at older ages. Males and females showed similar trends, though in general Negro males exceed white males in higher ratios than those of females.

It was shown that Negroes and whites had crude rates of 223.5 and 123.4 respectively, a ratio of 1.81 to 1. This comparison is distorted, however, by the fact that the general Negro population is younger than the white population of New York State. In fact, the median age of Negroes decreased between 1940 and 1950, whereas that of whites increased. It is necessary to correct for such differences, and the results are summarized in Table 7 in the form of standardized rates.

Negroes had an average annual standardized rate of 325.8 per 100,000 population during 1949–51. Males and females had corresponding rates of 365.2 and 280.5 respectively. The male rate was in excess by 30%. Compared with 1939–41, there were significant decreases. The rate fell from 377.4 in 1940 to 325.8 in 1950, a decrease of 14%. The male rate decreased more rapidly, falling from 435.1 in 1940 to 365.2 in 1950, or by 16%. The female rate decreased from 312.6 in 1940 to 280.5 in 1950, or by 10%. In consequence, the male rate, which was in excess of the female rate by 39% in 1940 was in excess by only 30% in 1950.

The trend differed significantly for the white population. The standardized rate

TABLE 6

Average annual rates of first admissions among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
under 10.....	7.9	2.1	5.0	3.7	0.7	2.2	2.14	3.00	2.27
10–14	91.4	110.1	101.0	17.6	11.4	14.6	5.19	9.66	6.92
15–19	246.0	212.8	227.9	82.6	73.1	77.8	2.98	2.91	2.93
20–24	422.6	193.0	287.7	141.9	96.9	118.3	2.98	1.99	2.43
25–29	366.4	216.3	282.1	128.4	114.6	121.2	2.85	1.89	2.33
30–34	314.9	215.5	258.3	105.8	118.6	112.5	2.98	1.82	2.30
35–39	259.3	237.2	246.8	105.6	118.9	112.5	2.46	1.99	2.19
40–44	277.4	190.0	230.1	109.1	124.2	116.8	2.54	1.53	1.97
45–49	222.3	177.3	198.7	113.6	132.3	123.0	1.96	1.34	1.62
50–54	249.6	243.1	246.3	127.4	135.2	131.4	1.96	1.80	1.87
55–59	324.7	242.8	282.6	144.2	143.0	143.6	2.25	1.70	1.97
60–64	383.1	383.9	383.4	184.6	159.9	172.3	2.08	2.40	2.23
65–69	615.7	471.3	532.6	255.3	209.4	231.2	2.41	2.25	2.30
70–74	715.8	720.7	718.6	386.4	363.3	373.9	1.85	1.98	1.92
75 or over....	1,488.7	1,248.9	1,332.6	797.8	792.8	795.0	1.87	1.58	1.68
TOTAL	252.3	199.2	223.5	121.7	124.9	123.4	2.07	1.59	1.81

rose from 147.0 in 1940 to 153.8 in 1950. The male rate varied insignificantly during the decade, but the female rate grew from 136.4 to 151.0. Thus, whereas the rate for male Negroes declined, that for whites was practically constant. Negro females showed a decline of 10% during the decade, compared with an increase of 11% among white females.

In consequence, the standardized rate for Negroes, which exceeded that of whites by almost 160% in 1940, was in excess in 1950 by only 112%. For males the rates were in the ratio of 2.35 to 1 in 1950, compared with a ratio of 2.82 to 1 in 1940. Among females the rate for Negroes remained in excess, but the ratio fell from 2.29 to 1 in 1940 to 1.86 to 1 in 1950.

The lowering of the general rate of first admissions among Negroes, in contrast to the marked increase during the preceding decade, may possibly be explained by relative improvement in the status of Negroes. This improvement may be seen in the shifting of the Negro population within New York City, which includes 80% of the total Negro population of New York State. In 1940 there were 458,444 Negroes in New York City, of whom 298,365, or 65.1%, were in Manhattan, primarily in Harlem. In 1950 there were 747,608 Negroes in New York City, of whom 384,482, or only 51.4% were in Manhattan. The greatest relative increase occurred in the Bronx. In 1940 this borough included only 23,529 Negroes, or 5.1% of the total Negro population. By 1950 the number living in the Bronx had increased four-fold to 97,752, or 13.1% of the total. The greatest numerical increase occurred in Brooklyn, where the Negro population grew from 107,263 in 1940 to 208,478 in 1950; the percentage of the total increased from 23.4 to 27.9. The number of Negroes in Queens County grew to 51,524 in 1950, twice that of 1940, but the percentage of the total Negro population grew only from 5.7 to 6.9.

In general, these changes meant an improvement in the gross environment of Negroes. Without exaggerating the degree of such improvement, it remains certain that living conditions among Negroes

TABLE 7

*Average annual standardized * rates of first admissions among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	365.2 ± 7.30	435.1 ± 9.92	0.84	155.3 ± 1.17	154.5 ± 1.18	1.01	2.35	2.82
Females ..	280.5 ± 5.73	312.6 ± 7.57	0.90	151.0 ± 1.11	136.4 ± 1.09	1.11	1.86	2.29
TOTAL	325.8 ± 4.59	377.4 ± 6.19	0.86	153.8 ± 0.81	147.0 ± 0.81	1.04	2.12	2.57

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 8

Negro first admissions with general paresis to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	Total
10–14	3	1	4	1.0	0.6	0.8	3.4	1.1	2.2
15–19	–	–	–	–	–	–	–	–	–
20–24	4	5	9	1.3	3.1	1.9	3.8	3.4	3.6
25–29	16	14	30	5.1	8.6	6.3	11.9	8.1	9.7
30–34	19	19	38	6.1	11.7	8.0	16.0	12.1	13.7
35–39	45	32	77	14.4	19.8	16.2	38.4	21.1	28.6
40–44	63	25	88	20.1	15.4	18.5	61.5	20.7	39.4
45–49	37	13	50	11.8	8.0	10.5	41.1	13.1	26.4
50–54	45	18	63	14.4	11.1	13.3	64.5	25.0	44.4
55–59	40	11	51	12.8	6.8	10.7	89.6	23.2	55.4
60–64	15	5	20	4.8	3.1	4.2	50.4	14.1	30.7
65–69	17	8	25	5.4	4.9	5.3	78.1	27.1	48.8
70–74	5	5	10	1.6	3.1	2.1	41.6	30.0	34.9
75–84	3	4	7	1.0	2.5	1.5	38.6	24.7	31.8
85 or over....	1	1	2	0.3	0.6	0.4	66.7	33.0	44.1
Unascertained	–	1	1	–	0.6	0.2	–	–	–
TOTAL	313	162	475	100.0	100.0	100.0	24.8	10.8	17.2

in Bronx, Kings and Queens counties are superior to those in the much older Negro centers in the heart of Harlem.

A further improvement in the status of Negroes is seen in education. In 1940 the median number of school years completed by Negroes aged 25 years and over was 7.8. By 1950 this had increased to 9.6. In 1940 3.7% had had no education and 65.9% had had some degree of elementary education. In 1950 the corresponding percentages had decreased to 3.0 and 51.5 respectively. The percentage with some degree of high school education increased from 23.2 in 1940 to 33.3 in 1950. The corresponding percentages for those with some degree of college education were 4.8 in 1940 and 6.7 in 1950.[3]

Still further improvement is shown by the fact that only 12% of the non-white males in the labor force in New York City in 1950 were unemployed, compared with 30% in 1940. For non-white females the corresponding percentages were 8.5 and 30 respectively.[4]

[3] These data are derived from the following reports issued by the U. S. Bureau of the Census:

Population. 1940. Second Series. Characteristics of Population. New York. 1942. Page 25.

Detailed Characteristics. New York. 1950. Bulletin P-C 32. Page 233.

[4] *Ibid.*

TABLE 9

Average annual rates of first admissions with general paresis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	–	–	4.9	2.8	3.8	–	–	–
20–24	3.8	3.4	3.6	3.4	4.3	3.9	1.12	0.79	0.92
25–29	11.9	8.1	9.7	27.9	13.5	19.7	0.43	0.60	0.49
30–34	16.0	12.1	13.7	78.7	20.1	45.7	0.20	0.60	0.30
35–39	38.4	21.1	28.6	91.8	23.3	54.7	0.42	0.91	0.52
40–44	61.5	20.7	39.4	78.0	33.4	55.4	0.79	0.62	0.71
45–49	41.1	13.1	26.4	134.0	35.1	84.1	0.31	0.37	0.31
50–54	64.5	25.0	44.4	143.1	26.7	83.4	0.45	0.94	0.53
55–59	89.6	23.2	55.4	101.1	36.3	67.4	0.89	0.64	0.82
60–64	50.4	14.1	30.7	95.1	65.1	79.4	0.53	0.22	0.39
65–69	78.1	27.1	48.8	119.7	21.0	63.6	0.65	1.29	0.77
70 or over....	42.3	29.4	34.4	85.4	13.4	41.2	0.50	2.19	0.83
TOTAL	24.8	10.8	17.2	54.5	16.4	33.9	0.46	0.66	0.51

Health, including mental health, is related to economic status. The amount of illness in a population decreases with a rise in economic level. It may therefore be inferred that the relative improvement in mental health among Negroes in New York State, as measured by first admissions to hospitals for mental disease, is associated with a rise in their economic level and with other environmental improvements.

GENERAL PARESIS

The widespread prevalence of syphilis among Negroes makes it a problem of great significance to public health. In the field of mental health it manifests itself by an excessive prevalence of general paresis and other disorders of syphilitic origin. Previous studies have shown that the greatest excess of rates of first admissions by Negroes over whites occurs in connection with general paresis. The data for 1950 confirm this conclusion.

There were 475 Negro first admissions with general paresis during the 3-year period 1949–51, or an average annual rate of 17.2 per 100,000 Negroes. The rate rose, in general, with advancing age to a maximum of 55.4 at ages 55–59 (Table 8). The rate increased among males to a maximum of 89.6 at ages 55–59, with an average rate of 24.8 for all male Negroes. Among females the rates rose to a maximum of 25.0 at ages 50–54, with an average rate of 10.8. The male rate exceeded that for

females in the ratio of 2.3 to 1. The relative excess of the males grew from 12% at ages 20–24 to almost 300% at ages 55–59.

Between 1930 and 1940 the average annual rate of first admissions with general general paresis grew among Negroes from 25.0 to 33.9. Between 1940 and 1950, however, there was a significant decline to 17.2, a decrease of 49%. The decrease occurred at all ages. In general, though the rates for males exceeded those for females, the former declined more rapidly during the decade. Between ages 25–55 the rates were reduced by approximately 50% to 60%. The rate of decrease was less at older ages. Among females the rates fell during the decade by approximately 40% up to age 45, declined by smaller amounts through age 64, but increased at ages 65 and over.

The white population had an average annual rate of 1.5 per 100,000 population. Males and females had rates of 2.2 and 0.8 respectively. In 1940 the white population had a rate of 5.8, indicating a decrease of 74% during the following decade, compared with a decrease of 49% among Negroes. Thus, though both whites and Negroes had declining rates of first admissions with general paresis, the decrease was relatively greater among whites, so that the relative excess of Negroes over whites increased during the decade. The relative excess was greatest at the youngest ages (Table 11).

The Negro population is relatively younger than the white population, a larger proportion falling within the age range associated with general paresis. This

TABLE 10

Average annual rates of first admissions with general paresis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	0.6	0.3	0.4	0.8	0.6	–	0.75	0.50
20–24	0.1	0.1	0.1	0.4	0.5	0.4	0.25	0.20	0.25
25–29	0.3	0.1	0.2	2.1	1.7	1.9	0.14	0.06	0.11
30–34	0.4	0.4	0.4	8.6	3.7	6.1	0.04	0.11	0.07
35–39	1.3	1.0	1.2	14.7	5.6	10.2	0.09	0.18	0.12
40–44	3.6	1.5	2.5	20.4	5.6	13.1	0.18	0.27	0.19
45–49	4.5	1.9	3.2	20.2	3.3	12.9	0.22	0.58	0.24
50–54	5.3	1.7	3.4	21.4	5.4	13.7	0.24	0.31	0.24
55–59	6.9	2.3	4.6	17.8	4.0	11.5	0.39	0.58	0.40
60–64	6.4	1.5	4.0	14.8	4.3	9.4	0.43	0.34	0.43
65–69	4.2	1.4	2.8	13.2	3.1	7.9	0.32	0.45	0.35
70 or over....	4.0	1.0	2.3	6.6	1.9	4.0	0.61	0.53	0.58
TOTAL	2.2	0.8	1.5	8.8	2.8	5.8	0.25	0.29	0.26

TABLE 11

Average annual rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	–	–	–	0.6	0.3	–	–	–
20–24	3.8	3.4	3.6	0.1	0.1	0.1	38.00	34.00	36.00
25–29	11.9	8.1	9.7	0.3	0.1	0.2	39.67	81.00	48.50
30–34	16.0	12.1	13.7	0.4	0.4	0.4	40.00	30.25	34.25
35–39	38.4	21.1	28.6	1.3	1.0	1.2	29.54	21.00	23.83
40–44	61.5	20.7	39.4	3.6	1.5	2.5	17.08	13.80	15.76
45–49	41.1	13.1	26.4	4.5	1.9	3.2	9.13	6.89	8.25
50–54	64.5	25.0	44.4	5.3	1.7	3.4	12.17	14.71	13.06
55–59	89.6	23.2	55.4	6.9	2.3	4.6	12.99	10.09	12.04
60–64	50.4	14.1	30.7	6.4	1.5	4.0	7.88	9.40	7.68
65–69	78.1	27.1	48.8	4.2	1.4	2.8	18.60	19.36	17.43
70 or over....	42.3	29.4	34.4	4.0	1.0	2.3	10.58	29.40	14.96
TOTAL	24.8	10.8	17.2	2.2	0.8	1.5	11.27	13.50	11.47

TABLE 12

*Average annual standardized * rates of first admissions with general paresis among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	38.6 ± 2.36	77.6 ± 4.20	0.50	2.8 ± 0.16	11.9 ± 0.33	0.24	13.79	6.52
Females	14.9 ± 1.33	23.4 ± 2.08	0.64	1.1 ± 0.10	3.4 ± 0.17	0.32	13.54	6.88
TOTAL	26.7 ± 1.32	49.4 ± 2.24	0.54	1.9 ± 0.09	7.4 ± 0.18	0.26	14.05	6.68

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

influences the relative incidence of general paresis among the races. It is therefore necessary to standardize the rates. These are shown for Negroes and whites for 1940 and 1950 in Table 12.

The standardized rate for Negroes fell from 49.4 in 1940 to 26.7 in 1950, a decrease of 46%. The decrease was more marked among males, the rate falling from 77.6 to 38.6, a decrease of 50%. The standardized rate fell among female Negroes from 23.4 to 14.9, or by 36%. The rate for males was in excess in 1940 in the ratio of 3.32 to 1. In 1950 the ratio was reduced to 2.59 to 1.

The standardized rate declined among the white population from 7.4 in 1940 to 1.9 in 1950, a reduction of 74% compared with a reduction of 46% among Negroes. The rate for white males decreased from 11.9 to 2.8, or by 76%. The rate decreased among white females from 3.4 to 1.1, or by 68%. Thus, as with Negroes there was a relatively greater decrease among males than females. In 1940 the rates for males and females were in the ratio of 3.50 to 1. In 1950 they were in the ratio of 2.54 to 1.

Thus, though the standardized rates of first admissions with general paresis decreased among both whites and Negroes, the relative excess of the Negro rate increased during the decade. In 1940 the Negro rate was in excess in the ratio of 6.68 to 1. This grew to 14.05 to 1 in 1950. We may conclude, therefore, that Negroes are benefiting from the application of methods to control the spread of syphilis, but that such measures have thus far been

TABLE 13

Negro first admissions with alcoholic psychoses to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	1	1	–	0.6	0.2	–	1.0	0.6
20–24	15	13	28	4.1	7.7	5.2	14.4	8.7	11.1
25–29	39	28	67	10.7	16.6	12.5	28.9	16.2	21.8
30–34	52	34	86	14.2	20.1	16.1	43.7	21.6	31.1
35–39	67	30	97	18.4	17.8	18.2	57.2	19.8	36.1
40–44	72	27	99	19.7	16.0	18.5	70.3	22.4	44.4
45–49	50	13	63	13.7	7.7	11.8	55.6	13.1	33.3
50–54	38	11	49	10.4	6.5	9.2	54.5	15.3	34.6
55–59	16	7	23	4.4	4.1	4.3	35.8	14.8	25.0
60–64	10	4	14	2.7	2.4	2.6	33.6	11.3	21.4
65–69	6	–	6	1.6	–	1.1	27.6	–	11.7
Unascertained	–	1	1	–	0.6	0.2	–	–	–
TOTAL	365	169	534	100.0	100.0	100.0	28.9	11.3	19.4

TABLE 14

Average annual rates of first admissions with alcoholic psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	1.0	0.6	1.6	–	0.8	–	–	0.75
20–24	14.4	8.7	11.1	18.6	7.4	11.8	0.77	1.18	0.94
25–29	28.9	16.2	21.8	43.9	15.3	27.3	0.67	1.06	0.80
30–34	43.7	21.6	31.1	72.6	22.0	44.1	0.60	0.98	0.71
35–39	57.2	19.8	36.1	59.7	23.3	39.9	0.96	0.84	0.90
40–44	70.3	22.4	44.4	89.9	20.6	58.1	0.78	1.09	0.76
45–49	55.6	13.1	33.3	91.1	19.3	54.9	0.61	0.68	0.61
50–54	54.5	15.3	34.6	61.3	14.6	37.4	0.89	1.04	0.93
55–59	35.8	14.8	25.0	58.3	14.4	35.6	0.61	1.03	0.70
60–64	33.6	11.3	21.4	53.5	5.4	28.4	0.63	2.09	0.75
65–69	27.6	–	11.7	46.0	7.0	23.8	0.60	–	0.49
70 or over....	–	–	–	32.0	–	12.4	–	–	–
TOTAL	28.9	11.3	19.4	42.4	11.9	25.9	0.68	0.95	0.75

more effective among the white population. The goal must be the more intensive application of preventive measures among Negroes, to reduce the disparity in comparison with whites.

ALCOHOLIC PSYCHOSES

Negroes have shown a great relative excess over whites in the frequency of alcoholic psychoses, the degree of excess being second only to that for general paresis. The data for 1950 repeat this comparison.

There were 534 Negro first admissions with alcoholic psychoses to all hospitals for mental disease in New York State during 1949–51 inclusive, or an average annual rate of 19.4 per 100,000 Negroes. The corresponding rate in 1940 was 25.9. This is a substantial reduction, and is in marked contrast to a rise from 15.1 in 1930 to 25.9 in 1940. The decrease occurred almost entirely among males; their rate dropped from 42.4 in 1940 to 28.9 in 1950. The female rates were 11.9 in 1940 and 11.3 in 1950.

The average annual rate increased with advancing age to a maximum of 44.4 at ages 40–44, and declined at higher ages. Among males the rate reached a maximum of 70.3 at ages 40–44. Females reached a maximum rate of 22.4 at the same age.

At every age Negro males had a lower rate in 1950 than in 1940 (Table 14). The reductions varied from only 4% at ages 35–39 and 11% at ages 50–54 to 40% at

the other ages. The maximum rate in 1940 was 91.1 at ages 45–49. The maximum in 1950 was only 70.3 at ages 40–44. Among Negro females, however, there was only one significant reduction, namely, from 19.3 in 1940 at ages 45–49 to 13.1 in 1950. On the other hand, the rate increased at ages 60–64 from 5.4 to 11.3. The female rates in 1950 exceeded those for 1940 at most ages, in contrast to males.

The white population of New York State had lower rates of first admissions with alcoholic psychoses than Negroes. The crude rates were 6.5 and 19.4 for whites and Negroes respectively. At ages 20–54 white males showed substantial reductions in rates between 1940 and 1950, though the relative reductions were not so great as those for Negro males. After age 55 the rates increased among whites, whereas they decreased among Negroes. As with Negro females the rates increased among white females between 1940 and 1950 in most age groups, resulting in an increase of the general white female rate during the decade.

Table 16 compares the average annual rates among Negroes and whites according to age. At every age the rate for Negroes was in significant excess. The degree of excess declined, however, with advancing age. The ratio of the corresponding rates fell steadily from 27.75 to 1 at ages 20–24 to a minimum of 1.04 to 1 at ages 65–69. The degree of excess varied between the sexes. Thus, rates for Negro males exceeded those for whites in ratios that declined from 14.40 to 1 at ages 20–24 to 1.40 to 1 at ages 65–69. With minor fluctuations, Negro

TABLE 15

Average annual rates of first admissions with alcoholic psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	0.2	0.2	0.2	–	–	–	–	–	–
20–24	1.0	–	0.4	0.8	0.1	0.4	0.13	–	1.00
25–29	3.2	1.1	2.1	4.9	1.4	3.1	0.65	0.79	0.68
30–34	7.5	1.7	4.4	12.6	3.2	7.8	0.60	0.53	0.56
35–39	12.0	4.6	8.2	22.1	3.7	12.9	0.54	1.24	0.64
40–44	20.4	7.6	14.0	24.3	4.2	14.3	0.84	1.81	0.98
45–49	26.2	7.0	16.4	26.9	4.4	15.8	0.97	1.59	1.04
50–54	25.8	4.5	15.1	27.9	5.6	17.1	0.92	0.80	0.88
55–59	25.4	5.7	15.6	22.7	4.8	14.0	1.12	1.19	1.11
60–64	22.1	4.7	13.4	21.1	4.9	12.8	1.04	0.96	1.04
65–69	19.7	3.4	11.2	16.8	2.3	9.2	1.17	1.48	1.22
70 or over....	5.4	0.9	2.9	4.4	1.3	2.7	1.23	0.69	1.07
TOTAL	10.5	2.7	6.5	11.7	2.2	7.0	0.90	1.23	0.93

females had higher rates than white females in ratios exceeding those for males at corresponding ages.

As with general paresis the Negro population is concentrated more heavily than whites at those ages which constitute the period of highest risk for alcoholic psychoses. Therefore, it is desirable to reduce the comparisons to a common standard (Table 17).

On this basis, the Negro rate was reduced from 36.0 per 100,000 in 1940 to 27.0 in 1950, a reduction of 25%. The reduction occurred principally among males, the rate falling from 58.8 in 1940 to 40.8 in 1950, a reduction of 30%. Among Negro females, however, the rate was reduced by only 3%, from 14.9 in 1940 to 14.4 in 1950. Thus, the ratio of the rates among Negroes was reduced from 3.94 to 1 in 1940 to 2.83 to 1 in 1950, implying a relative increase among Negro females when contrasted with males.

The rate for whites decreased from 9.8 in 1940 to 9.0 in 1950, a decrease of only 8%, compared with 25% for Negroes. The decrease among whites was limited to males, the rate having declined from 16.9 in 1940 to 14.8 in 1950. Among white females, however, the rate increased from 3.3 to 3.8. Whereas the male rate exceeded that for females in the ratio of 5.12 to 1 in 1940, the ratio was only 3.89 to 1 in 1950. Thus, rates for males are in substantial excess over those for females, but the disparity was reduced significantly in 1950.

Rates for the white population were at a lower level. In 1950 the standardized rates were 27.0 for Negroes, compared with

TABLE 16

Average annual rates of first admissions with alcoholic psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	1.0	0.6	0.2	0.2	0.2	–	5.00	3.00
20–24	14.4	8.7	11.1	1.0	–	0.4	14.40	–	27.75
25–29	28.9	16.2	21.8	3.2	1.1	2.1	9.03	14.73	10.38
30–34	43.7	21.6	31.1	7.5	1.7	4.4	5.83	12.71	7.07
35–39	57.2	19.8	36.1	12.0	4.6	8.2	4.77	4.30	4.40
40–44	70.3	22.4	44.4	20.4	7.6	14.0	3.44	2.94	3.17
45–49	55.6	13.1	33.3	26.2	7.0	16.4	2.12	1.87	2.03
50–54	54.5	15.3	34.6	25.8	4.5	15.1	2.11	3.40	2.29
55–59	35.8	14.8	25.0	25.4	5.7	15.6	1.41	2.60	1.60
60–64	33.6	11.3	21.4	22.1	4.7	13.4	1.52	2.40	1.60
65–69	27.6	–	11.7	19.7	3.4	11.2	1.40	–	1.04
70 or over....	–	–	–	5.4	0.9	2.9	–	–	–
TOTAL	28.9	11.3	19.4	10.5	2.7	6.5	2.75	4.19	2.98

TABLE 17

*Average annual standardized * rates of first admissions with alcoholic psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	40.8 ± 2.55	58.8 ± 3.86	0.69	14.8 ± 0.36	16.9 ± 0.41	0.88	2.76	3.48
Females	14.4 ± 1.36	14.9 ± 1.74	0.97	3.8 ± 0.18	3.3 ± 0.18	1.15	3.79	4.52
TOTAL	27.0 ± 1.38	36.0 ± 2.02	0.75	9.0 ± 0.20	9.8 ± 0.22	0.92	3.00	3.67

* Population of New York State aged 20 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

9.0 for whites, a ratio of 3 to 1. For males the rates were 40.8 and 14.8 respectively, a ratio of 2.76 to 1. Among females the rate for Negroes was in excess in the ratio of 3.79 to 1.

In 1940 the Negro male rate exceeded that of whites in the ratio of 3.48 to 1. This was reduced to a ratio of 2.76 to 1 in 1950. In 1940 the Negro female rate was in excess of that of white females in the ratio of 4.52 to 1. In 1950 the ratio declined to 3.79 to 1.

It is unlikely that selective factors, such as migration, were responsible for the change in the level of alcoholic psychoses among Negroes. The migratory element, defined as being born outside New York State, included the same proportion of Negroes (64%) in both 1940 and 1950. It is probable, therefore, that the same social factors which reduced the rate of alcoholic psychoses among whites also affected the Negro population similarly.

PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS

Psychoses with cerebral arteriosclerosis are related directly to the aging of the population. As those of advanced age (65 or over) increase in number, the number of first admissions with such psychoses may be expected to increase. The number of Negroes in New York State aged 65 years or over increased from 16,600 in 1940 to 35,495 in 1950. This age group included 2.9% of the total Negro population in 1940 and 3.9% in 1950. It is therefore important to consider the trend of psychoses with cerebral arteriosclerosis.

There were 781 such first admissions during the three years 1949–51, with an average annual rate of 28.3 per 100,000 Negroes. Males and females had rates of 28.6 and 28.0 respectively. These represent decreases compared with the corresponding rates for 1940 (Table 19).

The average annual rate increased with advancing age to a maximum of 878.4 at ages 80–84. The maximum for males was 1,068.4; that for females was 627.1 Generally, rates for males exceeded those for females at corresponding ages.

Rates for whites were lower than those for Negroes. White males had a rate of 25.2; females had a rate of 22.6. There was

an average of 23.9 for both sexes. The rates for males rose to a maximum of 500.9 at ages 85 and over. They rose among females to 321.8 at ages 80–84 and 308.4 at ages 85 and over. At all corresponding ages males had higher rates than females.

Table 19 shows comparisons of rates among Negroes in 1940 and 1950. At every age there was a reduction in rates during the decade. The differences between the two sets of rates decreased with advancing age. With minor exceptions, males and females both showed the same trend.

Rates of first admissions with psychoses with cerebral arteriosclerosis increased among whites between 1940 and 1950. This resulted from increases among those of advanced age (70 or over). At all other ages the annual rates were less in 1950 than in 1940, though the differences decreased with advancing age.

Table 21 compares the annual rates for Negroes and whites in 1950. The total rate for Negroes was in excess by 18%. Rates for Negroes were in excess at every age. The degree of excess declined, however, from a ratio of 9.64 to 1 at ages 45–49 to 1.85 to 1 at ages 75 or over. The trend was similar for each sex. In general, however, rates for Negro females exceeded those for white females in higher ratios than occurred among males.

It is always necessary to consider the differential age distributions of the two racial groups. The white population includes a higher proportion at advanced ages. Rates on a comparable base are therefore shown in Table 22.

TABLE 18

Negro first admissions with psychoses with cerebral arteriosclerosis to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	1	1	–	0.2	0.1	–	0.7	0.4
40–44	–	3	3	–	0.7	0.4	–	2.4	1.3
45–49	9	11	20	2.5	2.6	2.6	10.0	11.1	10.6
50–54	24	29	53	6.6	6.9	6.8	34.4	40.3	37.4
55–59	47	42	89	13.0	10.0	11.4	105.3	88.7	96.7
60–64	56	80	136	15.4	19.1	17.4	188.2	225.8	208.6
65–69	87	93	180	24.0	22.2	23.0	399.7	315.4	351.2
70–74	64	73	137	17.7	17.4	17.5	532.7	438.4	477.9
75–79	41	36	77	11.3	8.6	9.9	755.1	351.9	491.7
80–84	25	31	56	6.9	7.4	7.2	1068.4	768.3	878.4
85 or over....	9	19	28	2.4	4.5	3.6	600.0	627.1	618.1
Unascertained	–	1	1	–	0.2	0.1	–	–	–
TOTAL	362	419	781	100.0	100.0	100.0	28.6	28.0	28.3

TABLE 19

Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	0.7	0.4	–	3.9	2.1	–	0.18	0.19
40–44	–	2.4	1.3	6.6	14.2	10.4	–	0.36	0.13
45–49	10.0	11.1	10.6	19.7	35.1	27.4	0.51	0.32	0.39
50–54	34.4	40.3	37.4	112.5	87.5	99.7	0.31	0.46	0.38
55–59	105.3	88.7	96.7	194.4	183.2	189.1	0.54	0.48	0.51
60–64*	188.2	225.8	208.6	315.1	271.4	292.2	0.60	0.83	0.71
65–69	399.7	315.4	351.2	469.4	489.2	480.7	0.85	0.64	0.73
70–74	532.7	438.4	477.9	622.9	420.6	503.6	0.86	1.04	0.94
75 or over....	809.1	497.3	606.1	760.9	795.0	782.8	1.06	0.63	0.77
TOTAL	28.6	28.0	28.3	35.7	36.0	35.8	0.80	0.78	0.79

TABLE 20

Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	–	–	–	0.4	0.2	–	–	–
40–44	0.3	0.6	0.4	0.9	0.6	0.8	0.33	1.00	0.50
45–49	0.8	1.4	1.1	3.0	4.1	3.5	0.27	0.34	0.31
50–54	8.1	5.4	6.8	20.1	14.7	17.5	0.40	0.37	0.39
55–59	24.3	22.6	23.4	49.4	40.3	45.0	0.49	0.56	0.52
60–64	74.7	64.4	69.6	103.5	85.2	94.1	0.72	0.76	0.74
65–69	148.9	115.6	131.4	168.0	125.5	145.7	0.89	0.92	0.90
70–74	233.6	184.0	206.8	211.6	154.9	181.7	1.10	1.19	1.14
75 or over....	379.5	288.4	327.1	281.1	190.8	230.3	1.35	1.51	1.42
TOTAL	25.2	22.6	23.9	22.0	18.2	20.0	1.14	1.24	1.20

TABLE 21

Average annual rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	0.7	0.4	–	–	–	–	–	–
40–44	–	2.4	1.3	0.3	0.6	0.4	–	4.00	3.25
45–49	10.0	11.1	10.6	0.8	1.4	1.1	12.50	7.93	9.64
50–54	34.4	40.3	37.4	8.1	5.4	6.8	4.24	7.46	5.50
55–59	105.3	88.7	96.7	24.3	22.6	23.4	4.33	3.92	4.13
60–64	188.2	225.8	208.6	74.7	64.4	69.6	2.52	3.51	3.00
65–69	399.7	315.4	351.2	148.9	115.6	131.4	2.68	2.73	2.67
70–74	532.7	438.4	477.9	233.6	184.0	206.8	2.28	2.38	2.31
75 or over....	809.1	497.3	606.1	379.5	288.4	327.1	2.13	1.72	1.85
TOTAL	28.6	28.0	28.3	25.2	22.6	23.9	1.13	1.24	1.18

The standardized rate for Negroes was reduced from 253.2 in 1940 to 180.7 in 1950, a reduction of 30%. The male rate was reduced by 29%, from 254.8 in 1940 to 191.4 in 1950. The female rate was reduced by a third, from 235.0 in 1940 to 158.4 in 1950. The male rates exceeded those for females in both years, though the differences are not statistically significant.

Rates for the white population decreased

TABLE 22

*Average annual standardized * rates of first admissions with psychoses with cerebral arteriosclerosis among Negroes and whites, to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	191.4 ± 9.71	254.8 ± 14.78	0.75	75.4 ± 1.24	81.0 ± 1.39	0.93	2.54	3.14
Females ..	158.4 ± 8.24	235.0 ± 13.52	0.67	59.9 ± 1.08	61.0 ± 1.21	0.98	2.64	3.85
TOTAL ..	180.7 ± 6.43	253.2 ± 10.16	0.71	71.1 ± 0.84	73.0 ± 0.93	0.97	2.54	3.47

* Population of New York State aged 45 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 23

Negro first admissions with senile psychoses to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
50–54	1	1	2	1.0	0.5	0.7	1.4	1.4	1.4
55–59	–	3	3	–	1.4	1.0	–	6.3	3.3
60–64	8	15	23	8.1	7.4	7.6	26.9	42.3	35.3
65–69	18	23	41	18.2	11.3	13.6	82.7	78.0	80.0
70–74	13	39	52	13.1	19.2	17.2	108.2	236.4	181.4
75–79	24	45	69	24.2	22.2	22.8	442.0	439.9	440.6
80–84	16	51	67	16.2	25.1	22.2	683.8	1263.9	1051.0
85 or over....	19	26	45	19.2	12.8	14.9	1266.7	858.1	993.4
TOTAL	99	203	302	100.0	100.0	100.0	7.8	13.6	10.9

between 1940 and 1950, though the decreases were small and not significant.

The rate for Negroes exceeded that for whites in 1950. They were in the ratio of 2.54 to 1. Because of the more rapid decrease of the Negro rate, however, the excess was reduced between 1940 and 1950. In the former year the rate for Negroes was in excess in the ratio of 3.47 to 1.

Because of their more difficult lives it is probable that Negroes do not reach advanced age in as good physical condition as whites. Such influences would tend to raise the rates of first admissions with cerebral arteriosclerosis among Negroes above the level of those for whites.

SENILE PSYCHOSES

There were 302 Negro first admissions with senile psychoses during 1949–51. The rate per 100,000 population was 10.9. Males and females had rates of 7.8 and 13.6 respectively. Compared with the previous decade, there was a small but not significant decrease among males from a rate of 9.6 to 7.8. Females, on the contrary, increased their rate from 12.2 to 13.6. Males showed decreased rates at every age level between 1940 and 1950. There were similar decreases among females at all ages except 55–59.

Crude rates of first admissions with senile psychoses were higher among the white population. The average annual rate was 17.2 per 100,000. Males and females had rates of 13.2 and 21.0 respectively. The larger white population provides more stable rates, and these show a progressive increase with age to a maximum of 878.6 at 85 years and over. At each age level females had higher rates than males.

Unlike Negroes, the white population had higher rates of first admissions with senile psychoses in 1950 than in 1940. The rates rose from 11.8 to 17.2. Rates for males increased from 9.8 to 13.2. Among females

TABLE 24

Average annual rates of first admissions with senile psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
45–49	–	–	–	1.8	–	0.9	–	–	–
50–54	1.4	1.4	1.4	–	7.3	3.7	–	0.19	0.38
55–59	–	6.3	3.3	–	3.6	1.9	–	1.75	1.74
60–64	26.9	42.3	35.3	53.5	65.1	59.6	0.50	0.65	0.59
65–69	82.7	78.0	80.0	156.4	104.8	127.1	0.53	0.74	0.63
70–74	108.2	236.4	181.4	320.9	276.0	294.4	0.34	0.86	0.62
75 or over....	636.4	705.4	681.3	760.9	836.1	809.1	0.84	0.84	0.84
TOTAL	7.8	13.6	10.9	9.6	12.2	11.0	0.81	1.11	0.99

they increased from 13.8 to 21.0. The increased rates were limited, however, to those of advanced age. The rate rose by 10% among those aged 70–74 and by 22% among those aged 75 or over.

Table 26 compares rates of first admissions among Negroes and whites in 1950. It will be noted that the total crude rates were lower for Negroes. This is an artifact, however, due to the differing age structures of the two populations. A large proportion of the Negro population is aged less than 45 years. At corresponding ages over 45 the rates for Negroes were in significant excess. At ages 50–54, for example, the rate for Negroes was in excess in the ratio of 7.0 to 1. Rates for Negroes were in excess at all higher ages, but in decreasing ratios. Among those aged 75 and over the rate for Negroes was in excess in the ratio of 1.5 to 1.

Because of age differentials in the two populations it is necessary to standardize the rates. The standardized rate for Negroes fell from 109.0 in 1940 to 80.8 in 1950, a decrease of 26%. The standardized rate declined among males from 99.6 to 64.3 and among females from 99.5 to 80.8. The rate for females in 1950 was in excess of the male rate in the ratio of 1.26 to 1. Though the standardized rates for Negroes decreased in 1950, those for whites increased. The rate for whites rose from 45.2 in 1940 to 50.9 in 1950. The rate for males rose slightly from 37.4 to 39.3 but that for females rose significantly from 43.9. to 50.9. The relative excess of the female rate increased in 1950.

Despite the decrease among Negroes in 1950 their standardized rates remained in substantial excess over those for whites. In 1950 the rate for Negroes was in excess by 50%. In 1940, however, the rate for Negroes had been in excess by 140%. The future trend is not clear. The proportion of the aged is certain to rise, thereby increasing the number exposed to the risk of a senile psychosis. On the other hand, im-

TABLE 25

Average annual rates of first admissions with senile psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
40–44	–	–	–	0.1	–	•	–	–	–
45–49	–	–	–	–	0.2	0.1	–	–	–
50–54	0.1	0.3	0.2	0.6	1.3	0.9	0.17	0.23	0.22
55–59	0.4	1.2	0.8	1.7	3.0	2.4	0.24	0.40	0.33
60–64	8.3	11.1	9.7	11.2	17.6	14.4	0.74	0.63	0.67
65–69	32.3	42.9	37.9	30.8	52.4	42.1	1.04	0.82	0.90
70–74	108.1	152.5	132.1	110.6	127.4	119.6	0.98	1.20	1.10
75 or over....	394.0	493.7	451.3	356.0	379.1	369.0	1.11	1.30	1.22
TOTAL	13.2	21.0	17.2	9.8	13.8	11.8	1.34	1.52	1.46

• Less than 0.05.

TABLE 26

Average annual rates of first admissions with senile psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
45–49	–	–	–	–	–	–	–	–	–
50–54	1.4	1.4	1.4	0.1	0.3	0.2	14.00	4.67	7.00
55–59	–	6.3	3.3	0.4	1.2	0.8	–	5.25	4.13
60–64	26.9	42.3	35.3	8.3	11.1	9.7	3.24	3.81	3.64
65–69	82.7	78.0	80.0	32.3	42.9	37.9	2.56	1.82	2.11
70–74	108.2	236.4	181.4	108.1	152.5	132.1	1.00	1.55	1.37
75 or over....	636.4	705.4	681.3	394.0	493.7	451.3	1.62	1.43	1.51
TOTAL	7.8	13.6	10.9	13.2	21.0	17.2	0.59	0.64	0.63

TABLE 27

*Average annual standardized * rates of first admissions with senile psychoses among Negroes and whites, to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	64.3 ± 5.63	99.6 ± 9.25	0.64	39.3 ± 0.90	37.4 ± 0.95	1.05	1.64	2.66
Females	80.8 ± 5.89	99.5 ± 8.82	0.81	50.9 ± 0.99	43.9 ± 1.02	1.16	1.59	2.27
TOTAL	80.4 ± 4.29	109.0 ± 6.67	0.74	50.9 ± 0.71	45.2 ± 0.74	1.13	1.59	2.41

* Population of New York State aged 45 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

provement in physical health, consequent upon a rise in the standard of living, may keep down the level of such psychoses.

INVOLUTIONAL PSYCHOSES

There were 122 Negro first admissions with involutional psychoses during 1949–51, or an average annual rate of 4.4 per 100,000 Negro population. Females had a significantly higher rate than males, these being 6.2 and 2.3 respectively. The rates increased with age to a maximum of 29.3 at ages 54–59. The rates for females exceeded those for males at all ages. In general, females exceeded males in a decreasing ratio with advancing age.

The annual rate increased among Negroes from 3.6 in 1940 to 4.4 in 1950. Males and females both had increased rates during the decade. Males showed more significant increases, the rates growing at ages 45 and over.

The white population had an average annual rate of 11.7 per 100,000 white population in 1950, compared with 4.4 for Negroes. The rate for white females, 15.8, was twice that for white males, 7.4, and both were significantly in excess of the corresponding rates for Negroes. The rates rose to a maximum of 47.9 at ages 55–59. They rose to a maximum of 64.9 among females at ages 50–54 and reached a maximum of 35.1 among males at ages 55–59. The rate for females was in excess at ages 40–44 in the ratio of 6.7 to 1. The rates continued in excess at higher ages, but in a decreasing ratio.

The rate of first admissions increased among whites from 7.5 in 1940 to 11.7 in 1950 (Table 30). Males and females both showed substantial increases. There were increases at all ages, though the rates of increase were highest after age 50.

Table 31 provides a summary comparison of rates of first admissions with involutional psychoses according to age for Negroes and whites in 1950. Throughout the age ranges, rates for Negroes were lower than those for whites.

Table 32 provides a summary based upon

TABLE 28

Negro first admissions with involutional psychoses to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	3	3	–	3.2	2.5	–	2.0	1.1
40–44	–	6	6	–	6.4	4.9	–	5.0	2.7
45–49	7	30	37	24.1	32.3	30.3	7.8	30.2	19.5
50–54	7	26	33	24.1	28.0	27.0	10.0	36.1	23.3
55–59	10	17	27	34.5	18.3	22.1	22.4	35.9	29.3
60–64	4	9	13	13.8	9.7	10.7	13.4	25.4	19.9
65–69	1	2	3	3.4	2.2	2.5	4.6	6.8	5.9
TOTAL	29	93	122	100.0	100.0	100.0	2.3	6.2	4.4

standardized rates. Such rates increased among Negroes by 43%, rising from 8.6 in 1940 to 12.3 in 1950. The rate for females was significantly in excess of that for males in both years, but the rate for males grew more rapidly. It advanced from 2.5 to 6.9. The rate for females increased from 15.0 to 18.1.

The rate for the white population increased from 16.4 to 24.0, an increase of

TABLE 29

Average annual rates of first admissions with involutional psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
35–39	–	2.0	1.1	–	2.9	1.6	–	0.69	0.69
40–44	–	5.0	2.7	6.6	15.4	11.1	–	0.32	0.24
45–49	7.8	30.2	19.5	1.8	36.8	19.4	4.33	0.82	1.01
50–54	10.0	36.1	23.3	5.1	21.9	13.7	1.96	1.64	1.70
55–59	22.4	35.9	29.3	3.9	28.9	16.9	5.74	1.24	1.73
60–64	13.4	25.4	19.9	–	–	–	–	–	–
65–69	4.6	6.8	5.9	–	–	–	–	–	–
TOTAL	2.3	6.2	4.4	1.2	5.7	3.6	1.92	1.09	1.22

TABLE 30

Average annual rates of first admissions with involutional psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
25–29	–	0.1	•	–	0.1	•	–	1.00	1.00
30–34	–	0.6	0.3	–	0.1	0.1	–	6.00	3.00
35–39	0.3	3.7	2.1	0.3	2.0	1.2	1.00	1.85	1.75
40–44	3.5	23.6	13.8	4.9	19.1	12.0	0.71	1.24	1.15
45–49	13.0	47.4	30.4	11.0	41.4	25.9	1.18	1.14	1.17
50–54	27.0	64.9	46.1	21.3	49.8	35.0	1.27	1.30	1.32
55–59	35.1	60.7	47.9	21.4	34.0	29.2	1.64	1.79	1.64
60–64	30.1	39.0	34.5	12.0	18.8	15.4	2.51	2.07	2.24
65–69	19.3	19.1	19.2	9.4	8.4	8.9	2.05	2.27	2.16
70–74	6.6	5.4	5.9	2.2	3.3	2.8	3.00	1.64	2.11
75–79	1.1	0.6	0.8	0.6	–	0.3	1.83	–	2.67
80–84	0.7	1.1	0.9	–	–	–	–	–	–
85 or over....	–	1.0	0.6	–	–	–	–	–	–
TOTAL	7.4	15.8	11.7	4.4	10.5	7.5	1.68	1.50	1.56

• Less than 0.05.

46%. Rates for males increased from 10.1 to 15.3. Those for females increased from 23.3 to 33.6.

Thus, standardized rates of first admissions with involutional psychoses increased among both Negroes and whites. In both years, however, the rates for Negroes were only about half those for whites. The difference was more marked among males.

MANIC-DEPRESSIVE PSYCHOSES

The manic-depressive psychoses represent a group of low frequency among Negroes. There were only 48 such first admissions during 1949–51, or an average annual rate of 1.7 per 100,000 Negroes. As is usual with this group of psychoses, females had a higher rate than males, the rates being 2.4 and 0.9 for females and males respectively. With minor exceptions, females had higher rates at all ages from 20 to 69. Rates were highest at ages under 40, but no clear-cut trend appeared because of fluctuations due to small numbers.

The average annual rates for 1949–51 were less than those for 1939–41. Among Negro males the rates declined from 5.1 to 0.9. Among females they declined from 9.4 to 2.4. For both sexes combined they declined from 7.4 to 1.7, a decrease of 77%. Similar decreases occurred generally at all age levels (Table 34).

TABLE 31

Average annual rates of first admissions with involutional psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
25–29	–	–	–	–	0.1	*	–	–	–
30–34	–	–	–	–	0.6	0.3	–	–	–
35–39	–	2.0	1.1	0.3	3.7	2.1	–	0.54	0.52
40–44	–	5.0	2.7	3.5	23.6	13.8	–	0.21	0.20
45–49	7.8	30.2	19.5	13.0	47.4	30.4	0.60	0.64	0.64
50–54	10.0	36.1	23.3	27.0	64.9	46.1	0.37	0.56	0.51
55–59	22.4	35.9	29.3	35.1	60.7	47.9	0.64	0.59	0.61
60–64	13.4	25.4	19.9	30.1	39.0	34.5	0.44	0.65	0.58
65–69	4.6	6.8	5.9	19.3	19.1	19.2	0.24	0.36	0.31
70–74	–	–	–	6.6	5.4	5.9	–	–	–
75–79	–	–	–	1.1	0.6	0.8	–	–	–
80–84	–	–	–	0.7	1.1	0.9	–	–	–
85–89	–	–	–	–	1.0	0.6	–	–	–
TOTAL	2.3	6.2	4.4	7.4	15.8	11.7	0.31	0.39	0.38

* Less than 0.05.

TABLE 32

*Average annual standardized * rates of first admissions with involutional psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	6.9 ± 1.38	2.5 ± 1.03	2.76	15.3 ± 0.46	10.1 ± 0.40	1.51	0.45	0.24
Females	18.1 ± 2.04	15.0 ± 2.39	1.21	33.6 ± 0.66	23.3 ± 0.60	1.44	0.54	0.64
TOTAL	12.3 ± 1.74	8.6 ± 1.32	1.43	24.0 ± 0.41	16.4 ± 0.36	1.46	0.51	0.52

* Population of New York State aged 35 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 33

Negro first admissions with manic-depressive psychoses to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
20–24	1	8	9	8.3	22.2	18.7	1.0	5.4	3.6
25–29	3	8	11	25.0	22.2	22.9	2.2	4.6	3.6
30–34	4	4	8	33.3	11.1	16.7	3.4	2.5	2.9
35–39	1	6	7	8.3	16.7	14.6	0.9	4.0	2.6
40–44	1	4	5	8.3	11.1	10.4	1.3	3.3	2.2
45–49	–	1	1	–	2.8	2.1	–	1.0	0.5
50–54	–	1	1	–	2.8	2.1	–	1.4	0.7
55–59	1	2	3	8.3	5.6	6.2	2.2	4.2	3.3
60–64	1	1	2	8.3	2.8	4.2	3.4	2.8	3.1
65–69	–	1	1	–	2.8	2.1	–	3.4	2.0
TOTAL	12	36	48	100.0	100.0	100.0	0.9	2.4	1.7

TABLE 34

Average annual rates of first admissions with manic-depressive psychoses among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
15–19	–	–	–	4.9	9.8	7.6	–	–	–
20–24	1.0	5.4	3.6	15.9	7.4	10.4	0.06	0.73	0.34
25–29	2.2	4.6	3.6	9.3	16.2	13.4	0.24	0.28	0.27
30–34	3.4	2.5	2.9	6.2	17.2	12.4	0.54	0.14	0.23
35–39	0.9	4.0	2.6	3.4	18.4	11.6	0.26	0.22	0.22
40–44	1.3	3.3	2.2	1.3	11.6	6.5	1.00	0.28	0.34
45–49	–	1.0	0.5	14.3	8.8	11.5	–	0.11	0.04
50–54	–	1.4	0.7	7.7	7.3	7.4	–	0.19	0.09
55–59	2.2	4.2	3.3	3.9	3.6	3.7	0.56	1.17	0.89
60–64	3.4	2.8	3.1	–	–	–	–	–	–
65–69	–	3.4	2.0	–	–	–	–	–	–
TOTAL	0.9	2.4	1.7	5.1	9.4	7.4	0.17	0.26	0.23

Crude rates for whites exceeded those for Negroes. White males had a rate of 3.8; white females had a rate of 7.1. The average for both sexes was 5.4. The rates rose to a maximum of 10.6 at ages 40–44. Female rates rose to a maximum of 13.0, male rates to a maximum of 8.1, both at ages 40–44. Female rates were in excess through ages 65–69, but in a generally decreasing ratio. Thus, at ages 25–29 the female rate was in excess in the ratio of 3.51 to 1. The ratios declined steadily to only 1.06 to 1 at ages 50–54.

Rates of first admissions with manic-depressive psychoses decreased among whites between 1940 and 1950 but at a lesser rate than among Negroes (Table 35). They decreased among males by 33%, from 5.7 in 1940 to 3.8 in 1950. They decreased among females from 11.9 to 7.1, or by 40%. For both sexes combined the rates declined from 8.8 to 5.4, or by 61%. In general, rates of decrease were greater at younger ages, for example, under age 40.

Annual rates for Negroes and whites for 1950 are compared in Table 36. At every age rates for Negroes were significantly less than those for whites.

Final comparisons appear in Table 37, where the rates for 1940 and 1950 for both races were standardized on a common basis. The decrease in rates of first admissions

TABLE 35

Average annual rates of first admissions with manic-depressive psychoses among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
10–14	0.1	0.2	0.1	0.1	0.2	0.2	1.00	1.00	0.50
15–19	2.0	2.2	2.1	2.8	5.3	4.1	0.71	0.42	0.51
20–24	3.2	8.3	5.9	6.6	14.6	10.7	0.48	0.57	0.56
25–29	3.1	10.9	7.2	7.0	16.9	12.2	0.44	0.64	0.59
30–34	4.4	11.5	8.1	7.4	22.5	15.1	0.59	0.51	0.54
35–39	5.7	13.4	9.7	7.8	25.5	16.7	0.73	0.53	0.58
40–44	8.1	13.0	10.6	9.8	17.6	13.7	0.83	0.74	0.77
45–49	6.7	10.4	8.5	11.0	16.0	13.4	0.61	0.65	0.63
50–54	7.7	8.2	8.0	9.9	14.1	11.9	0.78	0.58	0.67
55–59	5.4	8.7	7.0	7.8	10.9	9.3	0.69	0.80	0.75
60–64	5.1	7.7	6.4	6.9	9.4	8.2	0.74	0.82	0.78
65–69	4.5	6.0	5.3	2.7	7.3	5.1	1.67	0.82	1.04
70–74	4.4	3.2	3.8	1.6	4.7	3.3	2.75	0.68	1.15
75 or over....	1.0	1.1	1.1	0.9	0.4	0.7	1.11	2.75	1.57
TOTAL	3.8	7.1	5.4	5.7	11.9	8.8	0.67	0.60	0.61

TABLE 36

Average annual rates of first admissions with manic-depressive psychoses among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
10–14	–	–	–	0.1	0.2	0.1	–	–	–
15–19	–	–	–	2.0	2.2	2.1	–	–	–
20–24	1.0	5.4	3.6	3.2	8.3	5.9	0.31	0.65	0.61
25–29	2.2	4.6	3.6	3.1	10.9	7.2	0.71	0.42	0.50
30–34	3.4	2.5	2.9	4.4	11.5	8.1	0.77	0.22	0.36
35–39	0.9	4.0	2.6	5.7	13.4	9.7	0.16	0.30	0.27
40–44	1.3	3.3	2.2	8.1	13.0	10.6	0.16	0.25	0.21
45–49	–	1.0	0.5	6.7	10.4	8.5	–	0.10	0.06
50–54	–	1.4	0.7	7.7	8.2	8.0	–	0.17	0.09
55–59	2.2	4.2	3.3	5.4	8.7	7.0	0.41	0.48	0.47
60–64	3.4	2.8	3.1	5.1	7.7	6.4	0.67	0.36	0.48
65–69	–	3.4	2.0	4.5	6.0	5.3	–	0.57	0.38
70–74	–	–	–	4.4	3.2	3.8	–	–	–
75 or over....	–	–	–	1.0	1.1	1.1	–	–	–
TOTAL	0.9	2.4	1.7	3.8	7.1	5.4	0.24	0.34	0.31

TABLE 37

*Average annual standardized * rates of first admissions with manic-depressive psychoses among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	1.3 ± 0.44	6.2 ± 1.19	0.21	5.0 ± 0.21	7.2 ± 0.25	0.69	0.26	0.86
Females	2.8 ± 0.57	9.7 ± 1.34	0.29	9.1 ± 0.27	14.8 ± 0.36	0.61	0.31	0.66
TOTAL	2.1 ± 0.37	8.0 ± 0.90	0.26	7.1 ± 0.17	11.1 ± 0.22	0.64	0.30	0.72

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

TABLE 38

Negro first admissions with dementia praecox to all hospitals for mental disease in New York State, 1949–51, classified according to age

AGE (years)	NUMBER			PERCENT			AVERAGE ANNUAL RATE PER 100,000 NEGRO POPULATION		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
under 10.....	9	3	12	0.6	0.2	0.4	3.7	1.3	2.5
10–14	40	50	90	2.9	3.6	3.2	45.7	55.1	50.4
15–19	136	119	255	9.7	8.6	9.1	169.0	124.1	144.6
20–24	326	186	512	23.3	13.4	18.4	312.4	125.1	202.3
25–29	336	270	606	24.0	19.4	21.7	249.2	156.1	196.9
30–34	226	232	458	16.1	16.7	16.4	189.8	147.5	165.7
35–39	147	235	382	10.5	16.9	13.7	125.4	154.8	142.0
40–44	89	131	220	6.4	9.4	7.9	86.9	108.7	98.7
45–49	50	73	123	3.6	5.3	4.4	55.6	73.5	65.0
50–54	26	53	79	1.9	3.8	2.8	37.3	73.6	55.7
55–59	7	17	24	0.5	1.2	0.9	15.7	35.9	26.1
60–64	3	13	16	0.2	0.9	0.6	10.1	36.7	24.5
65–69	2	4	6	0.1	0.3	0.2	9.2	13.6	11.7
70–74	1	2	3	0.1	0.1	0.1	8.3	12.0	10.4
75–79	–	1	1	–	0.1	•	–	9.8	6.4
Unascertained	2	–	2	0.1	–	0.1	–	–	–
TOTAL	1400	1389	2789	100.0	100.0	100.0	110.8	92.9	101.1

• Less than 0.05.

with manic-depressive psychoses is clearly evident. Among Negroes the rates declined by three-fourths, from 8.0 to 2.1. The rates for Negro males declined from 6.2 to 1.3, or by 80%. For females they declined from 9.7 to 2.8, or by 30%.

The rates also decreased among the white population, but at a lesser rate. Among males they decreased from 7.2 to 5.0, or by 30%; among females they declined from 14.8 to 9.1, or by 40%. The average for both sexes decreased by a third, from 11.1 to 7.1.

In each year the white population had higher rates of manic-depressive psychoses than did Negroes. In 1940 the rate for whites exceeded that for Negroes by 38%. In 1950 the rate for whites was again in excess but the disparity had grown, the excess amounting to 238%.

Thus, in contrast to the general relative distribution of the psychoses, Negroes definitely have lower rates than whites for the manic-depressive group. This cannot be explained by any of the environmental factors listed previously. We are therefore left with the hypothesis that the difference may result from racial characteristics, which, in this respect, are more favorable to Negroes.

DEMENTIA PRAECOX

The outstanding diagnostic category is dementia praecox. There were 2,789 such first admissions among Negroes during 1949–51 inclusive, giving an average annual rate of 101.1 per 100,000 Negro population. Males and females had rates of 110.8 and 92.9 respectively.

Dementia praecox is primarily a disease of the young. Half of such Negro first admissions were under 30 years of age. More than two-thirds were under age 35. Rates of first admissions are therefore weighted towards the young. There were very few first admissions with dementia praecox under age 10, but at ages 10–14 there was an average annual rate of 50.4. This increased rapidly to a maximum of 202.3 at ages 20–24 and then decreased steadily with advancing age. Through ages 30–34 male rates, with one exception, exceeded those for females. Beyond age 35 females had higher rates. The excess of the rates for females increased with advancing age.

Negro rates of first admissions with dementia praecox increased by 51%, from 67.0 in 1940 to 101.1 in 1950. The male rate increased more rapidly than that for females, advancing from 67.5 to 110.8, an increase of 64%. The female rate increased from 66.7 to 92.9, or by 39%. In general, the rates increased during the decade at all ages, but in higher ratios at the younger ages.

The white population had lower rates than Negroes. The average rate was 33.2

TABLE 39

Average annual rates of first admissions with dementia praecox among Negroes to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
10–14	45.7	55.1	50.4	7.6	1.4	5.2	6.01	39.36	9.69
15–19	169.0	124.1	144.6	95.1	85.6	90.0	1.78	1.45	1.61
20–24	312.4	125.1	202.3	189.8	89.2	128.0	1.64	1.40	1.58
25–29	249.2	156.1	196.9	142.3	105.5	122.3	1.75	1.48	1.61
30–34	189.8	147.5	165.7	112.0	117.7	115.2	1.69	1.25	1.44
35–39	125.4	154.8	142.0	75.7	102.8	90.4	1.66	1.51	1.57
40–44	86.9	108.7	98.7	59.5	63.0	61.3	1.46	1.73	1.61
45–49	55.6	73.5	65.0	37.5	70.2	54.0	1.48	1.04	1.20
50–54	37.3	73.6	55.7	33.2	26.7	29.9	1.12	2.76	1.86
55–59	15.7	35.9	26.1	27.2	61.7	44.9	0.58	0.58	0.58
60–64	10.1	36.7	24.5	–	21.7	11.3	–	1.69	2.17
65–69	9.2	13.6	11.7	9.2	14.0	11.9	1.00	0.97	0.98
70–74	8.3	12.0	10.4	–	–	–	–	–	–
75 or over....	–	5.8	3.8	–	–	–	–	–	–
TOTAL	110.8	92.9	101.1	67.5	66.7	67.0	1.64	1.39	1.51

TABLE 40

Average annual rates of first admissions with dementia praecox among whites to all hospitals for mental disease in New York State, per 100,000 corresponding population, 1949–51 and 1939–41

AGE (years)	AVERAGE ANNUAL RATE 1949–51			AVERAGE ANNUAL RATE 1939–41			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
10–14	7.4	5.4	6.4	1.6	1.8	1.7	4.63	3.00	3.76
15–19	52.6	42.8	47.6	33.1	26.8	30.0	1.59	1.60	1.59
20–24	100.1	62.8	80.5	64.2	44.4	54.1	1.56	1.41	1.49
25–29	83.6	73.4	78.3	61.4	51.7	56.4	1.36	1.42	1.39
30–34	60.7	69.6	65.4	51.7	46.8	49.2	1.17	1.49	1.33
35–39	50.5	61.1	56.1	41.5	48.5	45.0	1.22	1.26	1.24
40–44	38.0	47.0	42.6	29.5	33.8	31.9	1.29	1.39	1.34
45–49	26.2	34.7	30.4	22.1	27.3	24.6	1.19	1.27	1.23
50–54	16.6	22.9	19.8	13.7	18.6	16.0	1.21	1.23	1.24
55–59	12.3	17.2	14.7	10.0	14.1	12.0	1.23	1.22	1.23
60–64	7.3	10.9	9.1	4.3	7.4	5.9	1.70	1.47	1.54
65–69	3.8	6.4	5.2	2.4	4.4	3.4	1.58	1.45	1.53
70–74	1.1	2.5	1.8	–	2.1	1.1	–	1.19	1.64
75 or over ...	1.3	1.9	1.6	1.2	1.9	1.6	1.08	1.00	1.00
TOTAL	33.0	33.4	33.2	26.7	25.7	26.2	1.24	1.30	1.27

per 100,000 white population. Males and females had essentially equal crude rates. White first admissions with dementia praecox were significantly older than Negroes, and in both groups females were older than males.

Among whites the rate rose to a maximum of 80.5 at ages 20–24, and then fell steadily with advancing age. The maximum rate, 100.4, was reached by males at ages 20–24, but the maximum for females, 73.4, occurred at ages 25–29. Male rates were in excess through the latter age interval, but were exceeded subsequently by females. As with Negroes the rates for females exceeded those for males in an increasing ratio after the early years.

Between 1940 and 1950 the rate for whites increased by 27%, from 26.2 to 33.2. The male rate increased from 26.7 to 33.0, or by 24%. The female rate increased from 25.7 to 33.4, or by 30%. The rates of increase were less than those for Negroes. Among whites, as among Negroes, the rates increased during the decade at all ages, but, in general, rates for females increased more rapidly.

In 1950 the Negro rate exceeded that of whites in the ratio of 3.04 to 1. The excess was greater among males, Negroes being in excess in the ratio of 3.36 to 1. There was a smaller differential among females, Negroes being in excess in the ratio of 2.78 to 1. Throughout the age range the rates for Negroes exceeded those for whites.

The general Negro population of New

York State is younger than the white population. This influences the relative distribution of dementia praecox. Table 42 therefore provides summary rates on the basis of a common standard.

On this basis the standardized rates all showed increases during the decade. Among Negroes the rate increased from 71.8 in 1940 to 109.0 in 1950. The increase was relatively greater for males, among whom the rate increased from 73.4 to 119.7, an increase of 63%. The rates for females increased by 41%, from 70.1 to 98.6. Thus, the ratio of the male to female rate increased from 1.04 to 1 in 1940 to 1.21 to 1 in 1950.

The white population also increased its rates of first admissions with dementia praecox, though at a lesser ratio. Thus, the rate increased from 31.3 to 71.8, or by 36%, compared with an increase of 52% for Negroes. Rates increased among white males from 31.8 to 42.7, or by 34%, compared with 63% among Negroes. Rates for white females increased from 30.6 to 42.4, about equal to the ratio for Negro females.

Because of differences in the relative rates of increase, the difference in rates of first admissions between Negroes and whites increased during the decade. Thus, the Negro rate exceeded that for whites in 1940 in the ratio of 2.29 to 1, but this increased to a ratio of 2.55 to 1 in 1950. The increase was more substantial for males, the Negro rate being in excess in the ratio of 2.31 to 1 in 1940 but in excess in a ratio of 2.80 to 1 in 1950. The rate for Negro females was in

TABLE 41

Average annual rates of first admissions with dementia praecox among Negroes and whites to all hospitals for mental disease in New York State, 1949–51, per 100,000 corresponding population

AGE (years)	AVERAGE ANNUAL RATE AMONG NEGROES			AVERAGE ANNUAL RATE AMONG WHITES			RATIO		
	Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Males*	*Females*	*Total*
10–14	45.7	55.1	50.4	7.4	5.4	6.4	6.18	10.20	7.88
15–19	169.0	124.1	144.6	52.6	42.8	47.6	3.21	2.90	3.04
20–24	312.4	125.1	202.3	100.1	62.8	80.5	3.12	1.99	2.51
25–29	249.2	156.1	196.9	83.6	73.4	78.3	2.98	2.13	2.51
30–34	189.8	147.5	165.7	60.7	69.6	65.4	3.13	2.12	2.53
35–39	125.4	154.8	142.0	50.5	61.1	56.1	2.48	2.53	2.53
40–44	86.9	108.7	98.7	38.0	47.0	42.6	2.29	2.31	2.32
45–49	55.6	73.5	65.0	26.2	34.7	30.4	2.12	2.12	2.14
50–54	37.3	73.6	55.7	16.6	22.9	19.8	2.24	3.21	2.81
55–59	15.7	35.9	26.1	12.3	17.2	14.7	1.28	2.09	1.78
60–64	10.1	36.7	24.5	7.3	10.9	9.1	1.38	3.37	2.69
65–69	9.2	13.6	11.7	3.8	6.4	5.2	2.42	2.13	2.25
70–74	8.3	12.0	10.4	1.1	2.5	1.8	7.54	4.80	5.78
75 or over....	–	5.8	3.8	1.3	1.9	1.6	–	3.05	2.38
TOTAL	110.8	92.9	101.1	33.0	33.4	33.2	3.36	2.78	3.04

TABLE 42

*Average annual standardized * rates of first admissions with dementia praecox among Negroes and whites to all hospitals for mental disease in New York State, per 100,000 population, 1949–51 and 1939–41*

	NEGRO			WHITE			RATIO OF NEGRO TO WHITE	
	1950	*1940*	*Ratio*	*1950*	*1940*	*Ratio*	*1950*	*1940*
Males	119.7 ± 4.18	73.4 ± 4.08	1.63	42.7 ± 0.61	31.8 ± 0.53	1.34	2.80	2.31
Females	98.6 ± 3.40	70.1 ± 3.59	1.41	42.4 ± 0.59	30.6 ± 0.52	1.39	2.33	2.29
TOTAL	109.0 ± 2.66	71.8 ± 2.70	1.52	42.7 ± 0.43	31.3 ± 0.37	1.36	2.55	2.29

* Population of New York State aged 15 years or over on April 1, 1950 (in intervals of 5 years) taken as standard.

excess in both years, but the relative increase was not substantially different in 1950.

SUMMARY

This analysis of the frequency of mental disease among Negroes is based upon first admissions to all hospitals for mental disease in New York State during three years beginning October 1, 1948 and ending September 30, 1951. Comparisons were made with similar admissions during the preceding decade. Further comparisons were made with the white population of New York State during the same period.

Our first conclusion is that there are no racial differences between Negroes and whites with respect to mental disease—that is, there are no mental diseases which are limited to one race or the other. The same mental diseases occur among both races but in different relative frequencies.

The most frequent mental disorder is dementia praecox. A total of 45.2% of the Negro first admissions were included in this group, compared with 26.9% of whites. On the other hand, a third of the white first admissions were included in psychoses with cerebral arteriosclerosis and senile psychoses compared with only a sixth of the Negroes. General paresis included 7.7% of the Negroes and only 1.2% of the whites. The alcoholic psychoses included 8.7% of the Negroes, 5.3% of whites.

These differences were produced in part by the different age structures of the populations. Negroes in general were a younger population. It was necessary to achieve comparability by standardizing the rates of first admissions.

On this basis Negroes had a rate of 325.8 per 100,000 population, compared with 153.8 for whites. Furthermore, the rate for Negroes dropped by 14% between 1940 and 1950, whereas that for whites increased by 5%. The excess of the Negro rate dropped from 157% in 1940 to 112% in 1950.

The rate for Negro males decreased from 435.1 in 1940 to 365.2 in 1950; that of female Negroes decreased from 312.6 to 280.5. Rates for white males and females increased during the decade, though the increase among males was not significant.

The standardized rate for general paresis

dropped by 46% among Negroes. It fell from 49.4 to 26.7. Both sexes shared in the decrease, which was relatively greater for males. The decrease in rates of general paresis contrast with an increase during the period 1930–40.

General paresis also decreased among whites, the standardized rates decreasing from 7.4 to 1.9. The Negro rate was in excess in the ratio of 6.68 to 1 in 1940, but because of the more rapid decrease among whites the excess of the Negro rate increased to a ratio of 14.05 to 1 in 1950.

The standardized rate for alcoholic psychoses decreased among Negroes from 36.0 to 27.0. This was due almost entirely to a decrease of 31% among males from a rate of 58.8 to 40.8. The rate for Negro females was practically constant during the decade. Rates for whites decreased from 9.8 to 9.0. Again, this resulted from a decrease of 12% among males; on the contrary, the rate increased among white females from 3.3 to 3.8. Rates for Negroes were in excess in 1950 in the ratio of 3 to 1. The Negro rate in 1940 was in excess in the ratio of 3.67 to 1.

Psychoses with cerebral arteriosclerosis were reduced slightly among whites from a rate of 73.0 in 1940 to 71.1 in 1950. The rate decreased significantly among Negroes, however, from 253.2 to 180.7. The Negro excess was reduced from a ratio of 3.47 to 1 in 1940 to 2.54 to 1 in 1950. The disparity between Negro males and females increased from 8% in 1940 to 21% in 1950.

Senile psychoses increased among whites from a rate of 45.2 in 1940 to 50.9 in 1950. Among Negroes, however, the corresponding rates fell from 109.0 to 80.8. The decrease was relatively greater among Negro males. In 1940 Negro males and females had equal rates of such psychoses, but in 1950 the rate for females was in excess by 25%.

The involutional psychoses were one of two major groups which increased in frequency among Negroes. The standardized rate rose from 8.6 to 12.3. Rates rose similarly among whites from 16.4 to 24.0, the rate of increase being the same as for Negroes. It is significant, however, that the rate for Negroes was only half that for whites.

The standardized rate for manic-depressive psychoses decreased among Negroes from 8.0 to 2.1, a decrease of 74%. These psychoses also decreased among whites from 11.1 to 7.1, or by 36%. In both 1940 and 1950 rates for Negroes were less than those for whites. In 1950 the Negro rate was only 30% of that for whites.

In 1940 Negroes had a standardized rate of 71.8 for dementia praecox, compared with 31.3 for whites, or an excess of 129%. In 1950 the rate grew among Negroes to 109.0, an increase of 52%, and grew among whites to 42.7, an increase of 36%. The excess of the Negro rate increased to 155%. The rate for Negro males was significantly higher than that for Negro females. Among whites the sexes had equivalent rates.

Thus, it is clear that except for the involutional psychoses and dementia praecox there was a decrease in the rate of first admissions among Negroes between 1940 and 1950. This represents a significant change from the trend between 1930 and 1940. Despite the decrease of rates, however, those for Negroes remained in substantial excess over those for whites, with the exception of involutional psychoses and manic-depressive psychoses. The significance of the latter, especially for the manic-depressive group, is not fully understood, and raises questions as to the possibility of different degrees of emotional reactions.

The great majority of the differences *are* explicable, however, on the basis of migration and environment. It has been demon-

strated that migratory groups have higher rates of mental disease as measured by rates of first admissions.[5] Negroes in New York State are a highly migratory population, 60% having been born outside of New York State, compared with only 14% of the white population. In addition, Negroes suffer from low standards of living owing to economic disabilities. These disabilities were evidently less severe in 1950 than in 1940, as measured by economic and educational advances and by the wider dispersion of the Negro population within New York City. These have reduced, in general, the rates of first admissions among Negroes, and therefore point to the possibility of further improvement in the mental health of Negroes in New York State.

[5] Malzberg, Benjamin and Everett S. Lee, *Migration and Mental Disease: A Study of First Admissions to Hospitals for Mental Disease, New York, 1939–41.* New York, Social Science Research Council, 1956.

Book Reviews

STUDIES ON HYSTERIA

By Josef Breuer and Sigmund Freud

Translated and edited by James Strachey, with the collaboration of Anna Freud

New York, Basic Books, 1957. 335 pp.

This book rates more than routine interest in view of its historical position in psychiatry. It is the only major exposition of the collaborative work of Josef Breuer and Sigmund Freud, whose early concepts helped substantially in laying the foundations for modern dynamic psychiatry.

The cases and discussion in *Studies on Hysteria* provided a great impetus to a more general recognition of the psychological origins of what is today fully accepted as an emotional illness. Only 70 years ago this was not true at all. Then, around 1890, Charcot first reproduced hysterical symptoms, under hypnosis. Independently, and also stimulated by this, Breuer and Freud studied their bases, developed methods to further explore intrapsychic phenomena, and introduced several important concepts, presenting their findings and views in this interesting volume.

Herein they advance the important concept of "the unbearable idea" and the subsequent handling of this by the psyche. The unconscious, as a repository of consciously disowned data, is firmly established. Detailed case studies are presented and analyzed.

Another major concept, arrived at simultaneously by the authors and named by Freud, is conversion. Conversion is the name for the unconscious process through which intrapsychic conflicts, which would otherwise give rise to anxiety if they gained consciousness, instead obtain symbolic external expression. Since its introduction this conception has been developed and widened, so that today it is universally accepted. One may properly refer to somatic conversions, physiologic conversions, psychologic conversions and behavioral conversions. There is no up-to-date textbook in the behavioral sciences which does not utilize this term and associated ideas which were first advanced (with one early paper as an exception) in this volume.

Much of our subsequent research into the psychologic factors in mental and emotional illness has been based upon the early study of hysteria. The present volume, carefully retranslated and edited, is the first milestone in this direction. This book is accordingly recommended to all those who have an interest in the background and origins of modern psychiatry—HENRY P. LAUGHLIN, M.D., Chevy Chase, Md.

YEARBOOK OF EDUCATION

George Z. F. Bereday and Joseph A. Lauwerys, eds.

Yonkers-on-Hudson, World Book Co., 1958. 544 pp.

Mental health in education is treated with unusual care and thoroughness in the 1958 Yearbook of Education, which deals particularly with the secondary school curriculum. The terms *mental health* and *mental hygiene* are not particularly happy ones, however, in the opinion of W. D. Wall, who starts the discussion.

Dr. Wall says: "In the eyes of many, lay and professional alike, they suggest the area of mental ill health: psychiatric after-care service, maladjustment, care for mentally subnormal children and adults and the like, important preoccupations with which educationists are deeply concerned, but which are by no means coterminous with educa-

tion. Not unnaturally, too, the terms in the mouths and writings of those whose profession it is to deal with the markedly abnormal are suspect to those whose preoccupations lie with the normal child, his teacher, and his parents. A certain legitimately healthy resistance to what is often understood as the 'psychiatrization' of education has thus grown up; and, fortunately, it must be said, has protected the schools from well-intentioned meddling by those who, whatever their professional qualifications and insights in other fields, are too often the veriest amateurs as far as the teaching of children and adolescents is concerned."

In her discussion of mental health and the secondary school curriculum Bernice Milburn Moore of the Hogg Foundation, University of Texas, emphasizes the transition from a static definition of the mentally healthy person as "adjusted" to the dynamic concept of the personality as continuously adjusting, re-adjusting, changing and growing—no matter at what age. A close second in importance, she says, is "the study of healthy personality perceived as positive in development through effective socialization and interpersonal relations from infancy through childhood into youth and throughout adult years." Mental health then, Dr. Moore says, "by its coincidence in definition with the healthy personality—the normal personality—and by its concern for the development of effective, satisfying behavior relationships and action in society, is looked upon by many educators as a primary function of the schools."

Discussing the mental health implications of secondary education specifically, Dr. Moore says: "In the secondary schools of the United States recent attempts have been made not only to educate teachers in mental health, but to offer group experiences especially designed to acquaint youth with the dynamics of human behavior and the bases for effective interpersonal relations. Designation of these courses varies: Personal problems, personal relationships, human relations, personal and family living, home and family life education are some of the more prevalent.

"Perhaps the greatest opportunity to advance in the secondary curriculum as far as mental health of youth is concerned is in the application of sociological and social psychological principles of the group process to the learning of content. This blending of the traditional educational function of teaching facts with emotional and social participation as group members could make as radical a change in secondary education as has come in the education of the younger child."

Special emphasis in Dr. Moore's article is on the teacher. "To say that the teacher of youth should be a normal, healthy personality is to state the obvious," she says. "Morale and *rapport* in small groups depend to a large degree upon the leader. Teachers are, first and last, group leaders in an educational experience. Healthy personalities in teachers provide the best insurance secondary schools can offer that their educational practices, standards and philosophy will contribute to the emotional development of youth as they become normal adult personalities, productive and creative."—W. Carson Ryan, Chapel Hill.

PSYCHOTHERAPY OF THE ADOLESCENT

Benjamin Harris Balser, M.D., ed.

New York, International Universities Press, 1957. 270 pp.

Psychotherapy of the young adolescent is perhaps the greatest challenge to a psychia-

trist. Whether the young patient accepts treatment on his own or is urged or even ordered to accept therapy by the courts, the challenge continues to remain frustrating and even baffling to many a psychiatrist who deals with this age level.

To this end, then, Dr. Balser has very carefully selected a group of authorities in the field who, through their own personal experiences, have added materially to this very needed and necessary discipline. The management of the young adolescent is presented in various facets: psychotherapy in private practice, psychotherapy at school with inpatient treatment, psychotherapy of the adolescent in the clinic, or combined clinic and inpatient treatment, and finally psychotherapy of the adolescent in intensive hospital treatment.

This short tome becomes even more interesting when other collaborators present discussions of the various techniques with constructive criticism. To add a more personal component, one of the contributors presents a complete psychotherapeutic interview with an adolescent patient—a recording with dynamic comments. In addition, a schoolmaster, from his personal point of view, presents the psychotherapy of an adolescent.

Every one of the authors agrees that restlessness, confusion, impatience, instability, fluctuations of enthusiasm, infatuation, laziness, forgetfulness and inconsistencies are the challenge of the adolescent. They all agree that this age is still very much not completely understood and requires considerable understanding before any definitive attitudes can be presented for this highly complicated developmental period. With no exception they are in agreement that this type of patient requires continuing concentrated effort to unravel the mysteries of his position between childhood and young adulthood.

This book is a useful adjunct for the medical student, the psychiatric intern or resident in training, the social worker, and certainly for the psychiatrist in active practice.—Louis D. Boshes, M.D., Chicago.

THE CHRONICALLY ILL

By Joseph Fox, Ph.D.

New York, Philosophical Library, 1957. 229 pp.

Dr. Fox, director of the Home for Chronic Sick in Irvington, N. J., has drawn on his vast experience in the field in compiling this volume. He gives due consideration to the complexities involved in a work of this kind, and they are many, treating in turn the various aspects and problems encountered therein, and elaborating so far as the limitation of a single volume would permit.

This work will appeal equally to the seasoned specialist and the aspiring student who contemplates entering this field, and will provide a ready reference book of the most modern available knowledge and expert opinion. In its highly compressed nine chapters will be found an abundance of statistical analyses, and tabulations of facts and figures which have been obtained from the records of institutions throughout the country, and more especially from those in Maryland.

Stressing the point that may well alarm the average reader, Dr. Fox states that half the available bed space in the hospitals throughout the country is devoted to the care of the chronically mentally ill. The chronically ill, as distinguished from the mentally ill, occupy 45,000 beds, leaving 272,000 unprovided for; and the mentally ill are provided with 441,000 beds, with no provision for 352,000. These are staggering figures, and with increasing longevity

the problem of caring for the chronically ill becomes an ever-expanding one.

The author maintains that fully 75% of all chronically ill cases are homebound but that changing economics will in the future lower the number that receive home care. As for the mentally ill, while a large number of them are by no means incurable, still they require long-term care and overtax the available facilities.

Dr. Fox offers no panacea that will solve the problem. In the present work he describes conditions as they are today from the viewpoints of the medical supervisor, the victim, the institution and all others involved in the care of the chronically ill. Most of us will agree with him in believing that the nearest solution must be an enlarged and agumented program undertaken by the state.

The casual lay reader will be apt to find this book somewhat repetitious, but to those closest to the problem it should prove an incalculable aid.—MOTHER M. BERNADETTE DE LOURDES, Mary Manning Walsh Home, New York City.

HANDBOOK OF SPEECH PATHOLOGY

Lee Edward Travis, ed.

New York, Appleton-Century-Crofts, 1957. 1,088 pp.

Handbooks, reviews, encyclopedias and summary treatments of the subject matter in psychology and related fields have become the fashion. The routine excuse for such publications is, in L. E. Travis's own words, the fact that the science or, in this case, "speech pathology has grown away beyond the grasp of one man."

Publishers seemingly accept manuscripts of reference books with fewer compunctions than they do works of original scientific investigators. This practice often results in the publication of compendia containing a hodgepodge of unrelated articles of variable and inferior quality printed more for the benefit of the authors than the readers.

Fortunately, the *Handbook of Speech Pathology* is not just another such reference text. It is, in fact, a remarkable tome that might serve as a model for other scientific publications of its type.

Its 27 contributors are without exception either leading clinicians or research men in speech pathology. Their writing is uniformly superior. Verbal artistry as a substitute for knowledge is rare in its 1,088 pages.

The book is crammed with well-organized facts and long-incubated ideas. A sense of reality sustained by thoroughly assimilated experience takes precedence over doctrine, bias and self-defense in all departments, even in the section on psychotherapy.

My impression is that speech pathologists have reached an enviable level of ethical and professional maturation. An awareness of their delicate yet crucial position among other professionals is evident throughout the book. It tends to evoke in the reader a feeling of confidence in their achievement and also a sense of humility for what is not yet known.

The handbook is an ambitious, perhaps overambitious, undertaking, some will say. It has four parts: Part I, Basic Considerations in Speech Pathology, deals in eight solid chapters with developmental, neurophysiological, acoustic, phonetic and diagnostic problems, including instrumentation. Part II contains 14 chapters on speech anomalies related to deafness, aphasia, mental retardation, cerebral palsy and the malformations of speech organs. Part III includes eight highly informative chapters on the so-called functional articulation defects and on stuttering. Part IV concerns itself

with problems of psychotherapy and speech therapy.

Speech pathologists are beset by the dilemmas typical of other fields. They have not conquered the perennial challenges of such dichotomies as organic and functional, environmental and genetic, individual and group, intrapersonal and interpersonal, form and contents, skill and application, drill and motivation, child and parent, cause and effect. Yet they have coped with these annoying questions in more skillful and more realistic ways than can be found in other disciplines.

The handbook offers a most rewarding course of study for neurologists, psychiatrists, pediatricians, clinical and school psychologists, guidance counselors and speech therapists. In child welfare work hardly a day passes without the need for competent knowledge and sound advice concerning the manifold influences of normal communication skills on personality growth.

The book literally teems with ideas and suggestions for research and conceptual synthesis. Its overwhelming stress is on correction rather than prevention.

It is to be wondered if continued systematic surveys of the incidence of severe speech defects in young children might not lead to the discovery that some are caused by events analogous to those of blindness in rentrolental fibroplasia.—JOSEPH F. JASTAK, PH.D., Wilmington.

TEXTBOOK OF PSYCHIATRIC NURSING

By Arthur P. Noyes, Edith M. Haydon and Mildred van Sickel

New York, Macmillan Company, 1957. 415 pp.

Previously, the nurse-patient relationship has been handled as a separate and distinct part of nursing technique. This text introduces this relationship at the beginning and elaborates on it as the opportunity arises. This development of the nurse-patient relationship clarifies the nurse's role toward the patient while the text explains the diagnostic categories of psychoses and neuroses. It would seem a logical and simple blending of the two subjects.

This text should be most useful to professional students and to graduate nurses for both review and clinical teaching purposes. The terminology used would also make it beneficial to practical nurse students either as a text or as a reference source.

It seems to this reviewer that the text has unlimited use and value to any nurse or student nurse whether she is currently engaged in psychiatric nursing or in general nursing duties, since the nurse-patient relationship exists in all phases of nursing.

Although the nurse-patient relationship, as well as definitions of psychological behavior patterns, are traditionally taught during the psychiatric affiliations, these two phases in the development of students have wider application in the general work role of the nurse.—MRS. MARGARET MARSHALL, R.N., Essex County Overbrook Hospital, Cedar Grove, N. J.

THE DOCTOR, HIS PATIENT AND THE ILLNESS

By Michael Balint

New York, International Universities Press, 1957.

This is an important book and should receive attention from both general practitioners and psychiatrists. There is need for serious consideration of the role of the family doctor and the part he plays in the handling of illness. It is perhaps one of

the most urgent problems in the practice of medicine.

This book represents the results of a research project sponsored by the Tavistock Clinic of London. Headed by Dr. Michael Balint and Enid Balint, 14 general practitioners took part in the team approach. In the words of Dr. Balint, "Our chief aim was a reasonably thorough examination of the ever-changing doctor-patient relationship, *i.e.*, the study of the pharmacology of the drug 'doctor'."

The book is divided into three parts. The first nine chapters are chiefly concerned with a critical analysis of the problems to demonstrate what aspects are in need of revision. The next five chapters deal with the subject of psychotherapy by general practitioners. The final six chapters are more general, more reflective and inferential.

There have been minor attempts in this country to explore, with general practitioners, the area covered by this book. They have usually been short-term projects, highly didactic, more closely related to teaching and assuming that "the answers are known; it only remains to teach it to the needy." Dr. Balint's approach is different. He has projected a vast unknown area to be explored jointly by psychiatrist and practitioner on a long-term (2 or 3 years) continuing basis. Out of this project many new bits of learning have emerged. How to formulate them so that the reader may profit is in itself a research project of writing which Dr. Balint has carried through successfully.

This book should be widely read and discussed. If it receives the attention it deserves, it will likely be stimulating to small group projects of a similar pattern throughout this country.

Our #1 need in medical practice today is to assist the general practitioner in the handling of illness which is partly or wholly of psychogenic origin. It is likely that 50% of his patients are in this category, yet he has been taught nothing in most medical schools as to the treatment of this group. Dr. Balint's book is a large step toward an honest approach to this problem.
—Lewis H. Loeser, M.D., Newark, N. J.

PRESERVATION OF YOUTH

Essays on health translated by H. L. Gordon from the original Arabic (*Fi Tadbir Assihha*)

By Moses Ben-Maimon (Maimonides)

New York, Philosophical Library, 1958. 92 pp.

This monograph, which could be more aptly titled *The Preservation of Health,* was written in Arabic in 1198.

The author for the most part follows the ancient medical tradition of Galen. He places great emphasis on the type of food eaten—noodles, pancakes, peaches and apricots are very bad, rabbit's brain is good for head noises, the flesh of the wild ass strengthens vision, etc. The type of air breathed is also of great importance. He advocates suburban living with a northeast exposure and advises keeping pigeons in the house, since their aroma prevents neurological disorders. Bathing according to an elaborate ritual is healthful; one should always wash the head in the hottest water that can be tolerated, which hardens the substance of the brain. Extreme sexual abstemiousness is advised; "whoever wishes to remain healthy should chase the idea of intercourse from his mind as much as he can." He considers soft stools the foundation of health.

The great medical philosopher of the Middle Ages does have some very wise

things to say. He insists that no physician is better than an unskillful one, who is likely to thwart nature in its efforts to heal. He opposes phlebotomy and drastic purging except in rare cases. He says that one should employ attendants for the sick who can cheer the patient, tell gay stories and play musical instruments. He believes that emotional experiences cause marked changes in the body and its reactions. Strong self-discipline and a philosophical attitude toward life bring an equanimity which greatly contributes to health. "Mourning and sorrow over things that have passed are the activities of those who lack intellect."

This little volume gives a vivid picture of the best in medical practice during the Middle Ages.—MANFRED S. GUTTMACHER, M.D., Baltimore.

PERSONAL ADJUSTMENT; AN APPROACH THROUGH THE STUDY OF HEALTHY PERSONALITY

By Sidney M. Jourard, Ph.D.

New York, Macmillan Company, 1958. 462 pp.

Can one help personal adjustment through the study of the healthy personality? Most readers will remain unconvinced.

Furthermore, this volume does not advance the previous valuable contributions made to positive mental health. For these I refer the reader to George S. Stevenson, Abram Blau, Dorothy Conrad and many others. No matter how just may be the criticism of the physician's approach to personal adjustment as being weighed too heavily in the interest of pathology, it never excuses naïveté and the substitution of "faith" for science.

In any case the realization by Freud and others that the pathological illuminates its biological matrix has been most productive. So much so that accurate knowledge of the psychoanalytic approach has almost become a prerequisite before new formulations can be assured of successful application in our field. Nor does substituting other words for psychoanalytic concepts always result in clarification. For example, drives are called needs; denial, perceptual defense; isolation, verbal reformulation. "Objects" to me is still more accurate than "need objects." "Wants" is more descriptive than "need tensions." Furthermore, advice is presumptuous; at least it is awkward. In my opinion the author's advice to bored married couples or sexually frightened students may be misleading.

The thinking of Maslow, Sullivan and Fromm on the healthy personality constitutes a more solid part of the book. Most readers will agree that a self concept based on the real self, a feasible self ideal and an accurate public self indicates health. It may be a while, however, before many of us can make much practical use of these formulations as aids in personal adjustment. —DONALD A. SHASKAN, M.D., San Francisco.

ZEN FLESH—ZEN BONES

A collection of Zen and pre-Zen writings

Paul Reps, comp.

Rutland, Vt., Charles E. Tuttle Co., 1958. 211 pp.

Zen Flesh—Zen Bones—essentially a collection of Zen stories—proffers neither pleasure nor profit to anyone who is not already informed in Zen Buddhism. Taken literally, the text reads like the tales of a simpleton: "A Monk asked Toshu, a Chinese master: 'Has a dog Buddha-nature or not?' Toshu answered: "Nu!" "A Monk asked Baso: 'What is Buddha?" Baso said: "This mind is not Buddha.'" No after-dinner

anecdotes there! Nor enlightenment either—unless, of course, one had already fathomed the "meaning" of Zen.

Zen is the most precious distillate of the teachings of Buddha, "the most remarkable (of the) spiritual possessions bequeathed to Eastern people" (Suzuki). But Zen Buddhism is not to be fathomed save by dint of much study.

Since this is a review of the book and not of Zen, I can do no more than to counsel those interested to read Suzuki's work on Zen—Jung's introduction is most helpful—and revert to the work under review. It embodies 101 Zen stories: The Gateless Gate of Ekon; Ten Bulls by Kakuan; and Centering—transcribed by Paul Reps.

There is no describing the content of the work. The tales are somewhat reminiscent of Chassidic stories, but they differ in this essential respect: the latter nearly always bear a moral. The Zen collection bears none, save only perhaps "the lesson of Nothingness," or, to paraphrase it in the less unfamiliar language of the western mystic (Chassidic and Christian) "how to tap the Fluidium of Eternity."

The book itself is beautifully made. It is illustrated with a number of superb drawings reproduced as woodcuts, made by the 12th century Chinese master, Kakuan.

This is a work to be owned and treasured. Who knows but it may by some sympathetic magic entice one to taste more of the heady wine of Zen Buddhism?—IAGO GALDSTON, M.D., New York Academy of Medicine.

CRIME AND INSANITY

Richard W. Nice, ed.

New York, Philosophical Library, 1958. 280 pp.

This book is described as the product of a symposium by 12 experts in jurisprudence, psychology, psychiatry, sociology and education; it deals with the problems of the mentally ill who are accused of crime. It contains also an appendix summarizing replies to questionnaires sent to correctional, mental health and judicial leaders of the 48 states and the District of Columbia. Six questions were asked about state laws dealing with insanity as a defense to crime. The editor holds degrees in both social work and psychology and currently is working toward his Ph.D. in psychology at Arizona State College.

Several of the contributors, including Dr. Henry Davidson, Dr. William Haines, Simon Sobeloff, Prof. Henry Weihofen and Prof. Herbert Wechsler, present material similar to, if not identical with, material that they have previously published elsewhere. Dr. Davidson reports on the topic of irresistible impulse. Dr. Haines and John Zeidler summarize laws in various states dealing with insanity as a defense to crime. Mr. Sobeloff's article "From McNaghten to Durham and Beyond" duplicates a lecture that he delivered in May 1955 before the National Conference of Bar Councils. Prof. Ralph Winn, Prof. Donald R. Cressey and Prof. Herbert A. Bloch present philosophical discussions with reference to principles of punishment and describe differences in viewpoints among lawyers, sociologists and psychiatrists.

One chapter, by William F. Burke, Jr., entitled "New Light on the Eternal Conflict Between Law and Medicine in Judicial Practice" will be discussed in more detail inasmuch as the content of this chapter is quite different in tone and content from the rest of the book. Mr. Burke is described as the founder of the National Psychiatric Reform Institute in Albany, N. Y. On page 128 Mr. Burke writes, "In this enlightened day and age, patients, sad to say, are still being fraudulently committed in wholesale numbers to mental hospitals—where they

do not belong." In discussing the use of electroshock therapy for the treatment of patients with mental illness, he writes on page 130, "The human brain is the center of the nervous system, the seat of consciousness and volition. It is for this reason that the mentally ill person himself, if he is at all rational, should be permitted to sign for or refuse to submit to shock treatment." On the same and following pages he writes, "Operations without permission should be outlawed, and patients suffering from syphilis should not be forced to submit to spinal taps, because such spinal taps often injure the patient, causing him to become a paresis case years before he would have if the disease were allowed to take its normal course."

This reviewer challenges such statements and wonders if Mr. Burke could document his material.

The book contains many errors. The name of Judge David Bazelon is repeatedly misspelled as Bazelo. Incorrect listings of footnotes are made. In Dr. Davidson's chapter a statement is made that there are 12 states where irresistible impulses are defense to crime; in the footnotes only 11 states are mentioned; in Appendix II, on page 258, the statement is made that the irresistible impulse test exists in 14 states, in courts of federal jurisdiction and in the United States Army and that, in addition, another state has the delusional impulse test.

For those who are interested in this general subject and who have not read much of the literature, this book has some value inasmuch as it describes current attitudes of persons of different disciplines toward this controversial subject. It describes recent changes in laws in some jurisdictions and contains one chapter by Prof. Herbert Wechsler with reference to a proposed model penal code prepared by the American Law Institute.

In summary, this reviewer believes that this book has some merit for the reader who is interested in this general topic but who is not well versed in recent literature. The book, however, contains many errors which might be accepted as facts by the unsophisticated reader.—FRANK J. CURRAN, M.D., Children's Service Center, Charlottesville.

THE SCIENTIFIC STUDY OF SOCIAL BEHAVIOR

By Michael Argyle

New York, Philosophical Library, 1957. 239 pp.

This scholarly book, which summarizes and compares several hundred studies (a bibliography of 25 pages) of social behavior consists of two main parts: one on methodology, the other on generalizations and theories. The author is a lecturer in social psychology at Oxford University. The chief focus is on interaction between pairs of people, behavior in small social groups and human relations in industry. The emphasis is on the study of social interaction excluding personality and socialization. In general, theory is eschewed and an empirical point of view prevails—facts are put before theory.

The broad title of the book is inviting but leads to two important questions: What constitutes a "scientific" study? And what should "social behavior" include? The author's concept of science is clearly stated (p. 6): "The scientific approach consists in the first place in establishing empirical generalizations about the relations between a number of *measurable* (reviewer's italics) variables." He stresses that no valid conclusions can be drawn in the social sciences without statistical methods. In discussing the use of the "human instrument" (p. 31), the author says, "The human instrument

can be examined in exactly the same way as any other measuring device." Thus the author's conception of science is rather narrow, constricted, quantitative and dependent upon the measurability of a proposition. Concepts which may be tested and verified, even though not measurable, can be scientific if one believes in a broader range of science.

In a similar manner, consideration only of those aspects of social behavior which can be envisaged as measurable variables eliminates many vital aspects of social behavior. There is no doubt that one obtains a broad survey of the complex field of social behavior which lends itself to numerical considerations. However, one is left with doubts as to the meaningfulness of the material presented in its relation to the basic understanding of social behavior. The clinician (social worker, clinical psychologist, psychiatrist, etc.) may benefit from learning about methodology and techniques of measurement but would have difficulty in reconciling this type of data with the experience of dealing with human beings, individually and socially. Reversing the statement, can one anticipate that the author would learn about human behavior from the clinician, especially with his adoption of a restricted philosophy of science? The basic model of experimental psychology utilized by the author has not proved fruitful in the past for social workers, clinical psychologists and psychiatrists.

Even though the author avoids theory, his approach represents a specific theoretical position in his attitude toward facts. One might ask again: How do we agree as to what are the significant and relevant facts of social behavior which should be tested or measured if possible? The clinician is confronted with a difficult methodological problem when trying to do research in psychotherapy or in the field of social behavior. In psychotherapy or in psychoanalysis the treatment is a research process at the same time that it is a therapeutic process. Especially in psychoanalysis is there such an intimate interweaving of theory and practice. As far as the social sciences are concerned, what is lacking is a theory of personality. E. Shils in *The Present State of American Sociology* [1] clearly demonstrated the need for the sociologist to develop a satisfactory theory of personality.—JOSEPH J. MICHAELS, M.D., Belmont, Mass.

STUTTERING IN CHILDREN AND ADULTS

Thirty Years of Research at the University of Iowa

Wendell Johnson, ed.

Minneapolis, University of Minnesota Press, 1955. 472 pp.

The speech clinic of the University of Iowa is one of the oldest centers of research and treatment in its field and many of the leaders in speech therapy and workers in schools and clinics have been trained there. The results of 30 years of continuous research in stuttering, from 1924 to 1955, as well as the points of view of those in charge of it are therefore of major importance.

A bibliography of University of Iowa Studies of Stuttering through 1954 forming the appendix of this volume lists 266 publications and 153 graduate theses. The book contains 42 previously unpublished papers, most of which are short condensations of M.A. or Ph.D. dissertations. Notable exceptions are Johnson's "A Study of the Onset and Development of Stuttering" and Frederic L. Darley's "The Relationship

[1] Glencoe, Ill., Free Press, 1948.

of Parental Attitudes and Adjustments to the Development of Stuttering," which are published in full, and "Studies of Nonfluency in the Speech of Preschool Children" by Margaret E. Branscomb, Jeannette Hughes and Eloise Tupper Oxtoby, which is a condensation and coordination of three dissertations.

The editor devotes the first chapter of the book to a review of the part played by various persons, chiefly Dean Carl E. Seashore and his associates, in the early planning and development of the program, and to a more detailed commentary on the changing focus of interest as the years passed. The chapter constitutes the editor's own evaluation of the studies, most of which he directed, and it seems appropriate to follow his lead in reviewing the book.

The "dominance" theory of Samuel T. Orton, elaborated by Lee Edward Travis, first director of the Iowa Speech Clinic, motivated "most of the studies from the mid-twenties to the mid-thirties and many of those completed later . . . Prolonged and intensive investigation," says Johnson, "failed, so far as I can judge, to turn up any distinctive physical differences between stutterers and nonstutterers."

Gradually, by the mid-thirties, attention was directed to other approaches. Personality studies indicated that stutterers are essentially like nonstutterers and that their tendencies to be "a little more socially withdrawing and a little more inclined toward discouragement" are normal reactions "to the frustration and humiliation of stuttering."

The need for normative data on speech fluency in children led to investigations of childhood speech, the onset of stuttering and the relation of parental attitudes and adjustments to the development of stuttering. These studies "yielded substantial indications that the children who develop stuttering are essentially normal," but that the parent or other listener decides that the child's speech is not as it should be and expresses his judgments "in postures, frowns, or even actual statements that the child interprets as disapproval . . . What it comes to, so far as I can determine, is that the speaker (the child) responds to what the listener (the adult) does. And what the listener does seems to be more or less unnerving to the speaker, so that, while the responses and effects appear to be quite subtle and slow-working in most cases, the speaker's reactions to the listener's evident evaluations come in time to be marked by noticeable hesitation and tension. And as this development leads to more evident concern and disapproval on the part of the listener, so this more evident concern and disapproval are reacted to by the child with speech attempts that are correspondingly more unsure and strained. It is a vicious cycle, and, as such, it tends to expand."

Observation of the variability of stuttering in relation to "environmental" and "psychological" factors led Johnson to believe that the problem "might be approached by concentrating on *the moment of stuttering.*" Many studies followed which attempted to measure the frequency and the amount of stuttering by counting the moments of stuttering "in systematically obtained samples of speech."

Condensations of 15 of these studies make up Part IV of the book, covering 111 pages. They revealed the following basic phenomena: 1. the adaptation effect (the decrease in stuttering as measured with reference to its frequency or severity, that occurs when a stutterer reads the same passage a number of times consecutively); 2. the consistency effect (the tendency for stuttering to occur consistently in response to the same cues or stimuli); and 3. the spontaneous recovery of the strength of the stuttering re-

sponse (as measured with reference to its frequency or severity) subsequent to a sufficient interval of time following adaptation.

It is noteworthy (and the editor does note) that "the condition under which the data being discussed were obtained was that of oral reading in a laboratory situation" where, he says, less stuttering occurs and where the adaptation and recovery effects are more pronounced than during "so-called spontaneous or propositional speech."

Johnson concludes the chapter with a tentative theory of stuttering. He says: "At the present stage of the total research program, if we take into account not only the available data on adaptation, consistency, and spontaneous recovery, but also all the other findings reported to date, and the hypothesis already stated with respect to the onset of stuttering, a relatively rough theory may be attempted . . . Stuttering appears to be an anxiety-motivated avoidant response that becomes 'conditioned' to the cues or stimuli associated with its occurrences . . . This anxious or apprehensive expectation comes to be associated with and to be elicited by sounds, words, listeners, and other cues or features of situations in relation to which stuttering has been experienced in the past. Such cues, then, function as reminders, and so as 'storm signals' warning of 'danger ahead' . . . Stuttering, then, is what the speaker does trying to keep from stuttering—again . . . As the anxiety about stuttering is weakened, therefore, both the frequency and severity of the avoidant reactions—of the stuttering, that is—are reduced. Improvement is a function, then, of anxiety deconfirmation."

This observation comes at the end of the editor's review of the total stuttering research program at Iowa. One therefore might be led to believe that his theory of stuttering is based entirely on the results of that program. Such a conclusion, however, would ignore the fact that nowhere in the book is there a study of anxiety, motivation or anxiety-motivation alone or in relation to stuttering. The theory therefore appears to be based largely upon all the other findings reported to date and upon the author's hypothesis with respect to the onset of stuttering. This in no way detracts from the theory, but rather illustrates its author's breadth of vision and understanding.

The book offers much that is of value in addition to the story of the development of research in stuttering at Iowa. The condensed experimental studies reveal many facts not available elsewhere, and the three longer studies are a real contribution to the understanding of stuttering.—FREDERICK W. BROWN, Sewanhaka High School, Floral Park, N. Y.

FREE TIME: CHALLENGE TO LATER MATURITY

By Wilma Donahue, Woodrow W. Hunter, Dorothy H. Coons and Helen K. Maurice

Ann Arbor, University of Michigan Press, 1958. 172 pp.

While the two topics—the use of leisure time and the years of late maturity—are receiving increasing amounts of attention, they are still highly neglected interests. Our culture seems to cling to the idea that we are a "young" country with problems largely of youth and middle age, although reality dictates otherwise. The entire problem of free time and the later years is sharpened more clearly by twin facts—a lengthened life span and an earlier retirement.

About a century ago the individual worked 70 hours a week and the average life expectancy was around 40 years. Today the reverse is true. We have a 40-hour

week and a 70-year life expectancy with increasing amounts of leisure time on our hands.

This book tells how to employ one's free time with maximum benefits to the individual and to society. The highly competent authors indicate the importance of the joys gained from the use of one's faculties in creative expression and group endeavor.

Free Time: Challenge to Later Maturity contains discussions by sociologists, economists, educators, psychologists and physicians on how to prepare for the leisure of the later years. Psychological factors involved are evaluated and practical plans for creative endeavor are discussed. It is a valuable source book for planners as well as for intelligent laymen.—ARTHUR LERNER, Los Angeles City College.

PSYCHIATRIC INPATIENT TREATMENT OF CHILDREN

J. Franklin Robinson, M.D., ed.

Washington, American Psychiatric Association, 1957. 194 pp.

There is a spreading aura of optimism regarding the therapeutic management of severely disordered children who previously had been considered hopeless. Such children constitute catastrophic burdens to their families and to the community. Even now, treatment resources for these children are demonstrating the possibilities of extending the bounds of treatability. On the other hand, the current mushrooming of inpatient facilities for children before the establishment of suitable standards has engendered considerable confusion. The confusion has been increased further by the multiplicity of auspices which range from medical to social service to educational. In many cases the phrase "residential treatment" has even acted as a euphemistic façade for outdated placement facilities for dependent children. The 1956 conference on inpatient treatment for children was therefore very timely indeed. The report based on the conference proceedings should be read by all workers with children.

In view of the present uncertainty regarding treatment responsibility, the conference recommended that children's inpatient psychiatric treatment centers be called hospitals. An inpatient psychiatric treatment service—a psychiatric hospital for children—is defined as "a medical facility established for the diagnosis and treatment of children suffering from psychiatric disorders, in which the psychiatrist carried medical and corresponding legal responsibility for the diagnosis and treatment of the patient. It may be an independent institution or an identifiable medical unit in a medical or nonmedical agency."

With this general definition in mind, the conference focused on all major questions which need to be answered by those who plan for inpatient treatment of children. It considered such practical problems as architectural design, cost planning, staff selection, staff training, evaluation and research.

Most important, perhaps, the participants agreed on a general orientation to treatment. Treatment was viewed as the global impact of a child-centered atmosphere, where each child is offered a design for living which uniquely enhances his feelings of safety and his capacity for growth and self-regulation. In this regard the trend is toward community-rooted residential units with provision for adequate parental and community participation. Similarly, although it was recognized that the pressure for service to children is very great, opinion

tended to favor small open units which could permit meaningful and helpful interaction between adults and children.

All agreed that careful day-to-day programming, individualized education and warm, thoughtful child care by supervised and trained adults are the cornerstone of treatment. Within this kind of individualized climate, therapeutic procedure such as direct psychotherapy and drug therapy can be applied with appropriate perspective and maximal effectiveness. The modern point of view rejects the disorder and ignorance of mass custodial care of disturbed children. Apparently, too, child psychiatry now possesses a point of view and concrete tools for building adaptive equipment in ego-deficient children.—WILLIAM GOLDFARB, M.D., Henry Ittleson Center for Child Research, New York City.

Notes and Comments

Arthur S. Flemming, Secretary of Health, Education and Welfare, launched the national observance of Mental Health Week April 26 with the ringing of the historic Mental Health Bell at St. Elizabeths Hospital, federal mental hospital in Washington, D. C.

The 300-pound bell, symbol of the mental health movement, was cast in 1953 from chains and handcuffs formerly used to restrain mental patients. It is rung each year to start Mental Health Week.

Before the ceremony, Secretary Flemming, his family and other guests attended a religious service in the hospital chapel, together with several hundred mental patients. The Reverend Ernest E. Bruder, a hospital chaplain, preached a special Mental Health Week sermon.

The bell-ringing ceremony also signaled the beginning of Operation Friendship, nationwide Mental Health Week project aimed at bringing 750,000 visitors to mental hospitals across the country—as many visitors as there are patients. In many states and hundreds of localities, governors and mayors and their families were in the first contingent of hospital visitors.

Joining Secretary Flemming in ringing the Mental Health Bell were 4-year-old Mary Cornelia Link, of New York, the little girl pictured in the official Mental Health Week poster, several patients from St. Elizabeths, and the hospital director, Dr. Winfred Overholser. Also attending were Judge Luther Alverson of Atlanta, president of the National Association for Mental Health, and Dr. Robert H. Felix, director of the National Institute of Mental Health.

Judge Alverson said 800 state and local NAMH affiiliates were joined in Operation Friendship by thousands of local affiiliates of other national organizations in "what is probably the largest joint national venture ever undertaken by health and welfare organizations in this country's history." National organizations participating have a total membership in excess of 50,000,000.

Throughout the country the project had considerable impact. In Illinois, for example, an unprecedented 75,379 citizens visited the 12 mental hospitals and two schools for the mentally retarded during Mental Health Week. In New York City, the *New York Times* commended NAMH and Operation Friendship in a Sunday editorial beginning "The open-door policy at mental hospitals works best when the door opens both ways." In Pittsburgh, visits to Mayview Hospital were conducted by KDKA, a radio station of the Westinghouse Broadcasting Company, as part of the network's year-round campaign to promote better mental health.

In the words of those who evaluated the results of the project in Alabama: "Operation Friendship has offered an unusal opportunity in the mental health movement to dramatize and publicize the needs of mental patients and the goals of mental health associations everywhere. It has forcefully brought to the attention of the public that Mental Health is on the move and has focused that motion toward mental hospital patients.

"The direct results of Operation Friendship are visible, successful and therefore rewarding. It is safe to assume that this project has won new interest in mental health, increased awareness of the problems of mental illness, and new friends for the entire movement through the intensive public information campaign that led up to and accompanied Operation Friendship."

RESEARCH

The first grants made by the National Association for Mental Health under the

association's new research program were announced last month by Dr. William Malamud, director.

The grants were made to seven research scientists by the NAMH research committee at a meeting April 6. The scientists, the titles of their projects and the amounts of the grants follow:

- Dr. Ernst Prelinger, Yale University, $2,000 for a study of character structure and related ego functions.
- Dr. John I. Nurnberger, Indiana University Medical Center, $5,000 for a study of the effect of a special environment on psychotic (schizophrenic) children.
- Dr. James Maas, University of Cincinnati, $1,100 for a study of the relationship of free anxiety vs. the "schizophrenic process" to alterations in biochemical measures.
- Dr. Eugene Roberts, City of Hope Medical Center, $9,000 for a study of physiological and biochemical correlations of the role of gamma-aminobutyric acid in the central nervous system.
- Dr. William G. Clark, University of California Medical Center, $8,000 for a study of adrenergic transmitters and modulators.
- Dr. J. S. Gottlieb, Lafayette Clinic, Detroit, $10,000 to continue a study of intermediary carbohydrate metabolism in schizophrenia.
- Dr. Theodore X. Barber, Worcester Foundation for Experimental Biology, Shrewsbury, Mass., $13,639 for a study of hallucinatory behavior in schizophrenics and normals.

The NAMH research department has received 35 applications for grants totaling about $400,000. The committee expects to act on some of these at a meeting in June.

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Two research projects to reduce the number of inpatients admitted to mental hospitals, involving the use of psychiatric home treatment and a study of alternatives to hospitalization for geriatric patients, are now underway at the Boston University School of Medicine and Boston State Hospital.

Both programs are supported by grants from the U. S. Department of Health, Education and Welfare. They are under the direction of Dr. Walter E. Barton, associate professor of psychiatry and superintendent of the hospital.

The home care study at Boston State Hospital is the first such project in the United States. Similar experiments have proved successful in England and Holland, where home care has been practiced for over 25 years. According to Dr. Barton, this offers the first hope that mental hospitals can cut down their admission rate.

Two teams, each consisting of a doctor, a psychiatric social worker and a psychiatric nurse, are now working in the Dorchester area of Boston, a community of 100,000 residents belonging predominately to the middle- and lower-income classes, with mixed ethnic and religious backgrounds. The doctors use psychotherapy as their primary tool, as they would if they were seeing patients in their office or in an out patients clinic.

The geriatric project is being carried out in two stages. The first, now in progress, involves extensive interviews of 75 geriatric patients admitted to the hospital, their families, friends and associates, to get as complete a picture as possible of the needs of older people, where in their lives they failed to provide for these needs, and what can be done to maintain them in their home surroundings. In the second step the data will be analyzed to see what types of community resources are needed to allow these

people to remain in their home communities, instead of admitting them to mental hospitals.

Both projects require extensive work outside the hospital. When the home care program came into existence, the researchers saturated the community with information about the project. They personally told each community agency, doctor, clergyman, police surgeon and others that the home care service could be called when hospitalization was needed. In this way they are able to keep track of every patient in the Dorchester area who requires institutional care.

In the geriatric program, spot checks will be made of geriatric admissions to general hospitals, nursing homes and clinics. If the check shows a different pattern from the survey of Boston State Hospital patients, it will be pursued until proved statistically significant.

When the home care service is called, there are two alternatives. Either a doctor and a social worker go directly to the home or the psychiatric nurse goes, observes and then calls the doctor to report her observations. When both the doctor and the social worker go, the social worker deals with the patient's family and their problems while the doctor talks to the patient.

If the doctor feels additional care is needed, he will recommend it to the patient, making the widest possible use of community resources such as drug therapy administered by the family physician or referral to a clinic. In each case, the doctor makes at least one visit to the patient's home; the average is 4 to 6, and one patient was visited 44 times.

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A state-by-state study of mental health research in the South has been launched by the mental health program of the Southern Regional Education Board, according to Dr. William P. Hurder, director of the program and the study.

The study is designed to get detailed information about the South's resources and needs in research on mental health and behavioral science, including mental retardation. It will also provide a reliable estimate of research projects in progress and how they are being carried out.

Over 2,000 questionnaires have been distributed to research personnel and administrators throughout the region with the cooperation of a committee of research survey chairmen appointed by the governor of each participating state. Analysis of the completed questionnaires is already in progress. The results of the study will be made available through publications and will also be presented at a meeting of educators, legislators and researchers in the fall.

The cooperation of the Bio-Sciences Information Exchange and the Council of State Governments will supplement the study findings and broaden the scope of the data gathered. The exchange is supplying information about current research activities (in the region and the nation) supported by national granting agencies. It is also making its services available for recording and analyzing data on research in progress which come out of the SREB study. The Council of State Governments will provide data it has collected from the 48 states on methods of organizing and financing state-supported research in mental health and related areas.

Referring to the need for this type of study, Dr. Hurder cited a remark by Admiral Hyman G. Rickover pointing out that the home permanent wave industry budgets for research into ways of improving the looks of human hair a sum amounting to 2¢ per female in the U. S. The whole nation, meanwhile, spends only 3¢ per capita

for research into what goes on inside the head.

The regional mental health program was established in 1954 by the SREB at the request of the Southern Governors' Conference and is supported by an appropriation of $8,000 from each participating state. Its purpose is to aid states and Southern colleges and universities to train more qualified personnel for mental health programs and to aid in securing added support for needed research programs.

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Dr. William Malamud, director of research for the National Association for Mental Health, gave the first of a series of lectures honoring Dr. David C. Wilson, retired chairman of the psychiatry department at the University of Virginia School of Medicine. The association's new research program was one of the topics covered in his discussion of current research in psychiatry.

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A major discovery in the treatment of cretinism has been reported by doctors at the University of Michigan Medical Center. For the first time in medical history they have counteracted the dread disease by treating the patient before birth.

The work thus far has been on a limited scale, but the doctors have successfully stopped cretinism in one child. The treatment has had no ill effects either on mothers or their children.

Cretinism is a congenital disorder caused by improper functioning of the thyroid gland. It produces irreparable damage to the brain, physical deformity and idiocy.

A medical research team headed by Dr. Edward A. Carr and Dr. William H. Beierwaltes conducted extensive studies of the disease before applying their findings to the correction of the disorder. They determined that any cure for cretinism would have to be started before the patient was born. Once the child is born most of the damage has already taken place.

Two supporting discoveries led to finding the successful treatment, Dr. Beierwaltes said. One was a statistical finding that a woman who gave birth to two cretins had a very great chance of producing a cretin in her next pregnancy. The second came from work with animals. The scientists discovered that strong doses of thyroid extract given to mothers during pregnancy would be transmitted to the fetus.

Ready to test their work on humans, they found two women who, statistically, were likely to give birth to cretins. The women were given massive doses of thyroid extract —seven times the normal daily dosage prescribed for underactive thyroid glands— throughout the remainder of their pregnancies. Both delivered non-cretinous children. One child, they found subsequently, had no thyroid gland. He definitely would have been a cretin if the treatment had failed.

Dr. Beierwaltes said the next stage in their study will be to seek a method for diagnosing cretinism in advance in a couple's first child. At present they can predict it only on the basis of two previous cretins.

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A composite list of 137 research studies on psychopharmacologic drugs being conducted under support of grants from the National Institute of Mental Health is now available.

As classified by the institute's Psychopharmacology Service Center, the studies fall into three main categories: 57 studies directly related to problems of drug development and assessment; 68 studies of the basic mechanisms of the action of psychopharmacological agents; 12 studies pertain-

ing to method development and data analysis.

The drug development studies include research related to synthesis of new drugs, screening of drugs in animals and normal subjects, early clinical screening, and controlled clinical trials on patients with schizophrenia, depressions or neurotic conditions.

Single copies of the list of research grants, divided by category and including the name of each investigator, his institution and a brief description of his project, are available on request from NIMH, Bethesda 14, Md.

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The National Committee on the Aging announced in April that it had received an $18,000 grant to conduct a study of dependency and guardianship of older people. The grant was made by the Frederick and Amelia Schimper Foundation of New York.

The committee decided to make the study after surveys revealed many older people could not handle their own affairs, financial and otherwise, because of mental or physical deterioration. A number of agencies, including the Bureau of Old Age and Survivors Insurance and the Bureau of Public Assistance have in recent years requested the National Committee on the Aging to make a study of this problem.

The committee, a nonprofit national resource for planning, information and consultation on aging, is a standing committee of the National Social Welfare Assembly.

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In the next five years the Rockefeller Foundation will contribute $41,000 toward biochemical research on mental disease at Oxford University. This will assist further exploration of a theory that mental disease, particularly schizophrenia, may be related to abnormal chemical factors. Partition chromatography—a method of isolating single chemical compounds from mixtures —will be used to analyze the body fluids of schizophrenics and of a control group.

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A chromosome count of 47 has been found in six typical mongoloids by a research team headed by Patricia Jacobs at Edinburgh's Western General Hospital. "It appears," the scientists note, "that the condition of mongolism is associated with the presence of an extra chromosome."

Among the many implications of their findings is "the association of a predisposition to leukemia in a group of individuals with an abnormal karyotype which is clearly of great interest and potential importance. The significance of this association in relation to possible mechanisms of carcinogenesis remains to be elucidated," the researchers add.

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Two studies of the effect of special day training classes for children who are severely retarded mentally are being carried on with federal funds approved by U. S. Commissioner of Education Lawrence G. Derthick.

A 5-year study by the University of Illinois will compare the performance of retarded children in a special class with that of other children similarly retarded in regular school classes. All will be 6-year-old first graders. Their performance will be rated for four years.

A 2-year study is also going on at San Francisco State College.

LEGISLATION

Paul Johnston of Birmingham, a member of the legislative committee of the National Association for Mental Health, was to testify May 28 before the Senate subcommittee on appropriations for labor, health, educa-

tion and welfare, in support of a $74,000,000 budget for the National Institute of Mental Health.

Speaking for the association, he planned to present to this committee, chaired by Sen. Lister Hill of Alabama, many of the same facts he presented April 16 before the House subcommittee on appropriations.

Subsequently, on April 30, the House approved, without dissent, a budget of $60,409,000 for NIMH—$8,025,000 more than was recommended by the administration but $14,000,000 less than NAMH and the American Psychiatric Association recommend. The House also accepted the NAMH recommendation that funds for the construction of research facilities be increased from $20,000,000 to $30,000,000.

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Gov. Robert B. Meyner of New Jersey asked the state legislature for $30,583,445 for mental health—less than the $32,543,582 recommended by the State Department of Institutions and Agencies, still less than the $34,211,086 requested by the five state hospitals, but a little more than last year's $29,608,442.

At present New Jersey's state mental hospitals have $4.83 a day for each patient—compared to the $11.43 spent by the Veterans Administration hospital at Lyons.

"This disparity results from public indifference, lack of information and lack of funds, which the New Jersey Association for Mental Health and its 15 county chapters are trying to overcome through public education," said Dr. Edward P. Duffy, Jr., president.

The association has pledged its support to state officials in the correction of deficiencies resulting in the loss of national accreditation by 4 of New Jersey's 5 state mental hospitals. Dr. Duffy said the association views the loss as a dramatic and timely illustration of the need for more funds to provide more trained personnel to treat the 21,000 hospitalized mental patients.

Accreditation was lost by the Trenton, Marlboro and Greystone Park state hospitals and by the Neuropsychiatric Institute (Skillman). The fifth state hospital, Ancora, received only a 1-year approval.

A bill before the New Jersey legislature provides for reconstitution of the Commission on Mental Health.

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A brochure outlining Ohio's mental health needs was put in the hands of each member of the state's General Assembly by the Mental Health Federation, Inc.

The federation urged the legislators:

- To sign the Interstate Compact providing for the care and treatment of non-resident mental patients living in Ohio.
- To set up a separate State Department of Mental Health and a Bureau of Alcoholism.
- To provide more funds so that more patients could be treated by trained psychiatric personnel.
- To expand the state's mental health research program.
- To increase the number of mental health clinics.
- To provide funds for new treatments and rehabilitation services.
- To increase the state subsidy for community classes for the mentally retarded.
- To modify the laws governing state hospital admissions and the liability of patients (and their relatives) for the cost of treatment.

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Key members of the Connecticut Association for Mental Health pleaded for more funds for the state mental health depart-

ment at recent hearings before the appropriations committee of the legislature. The department is asking for $58,900,000 but Gov. Abraham A. Ribicoff has recommended $14,600,000 less—only $44,300,000.

Association spokesmen say the Governor's figure "falls $4,200,000 short of what is needed to stand still" (because of mandatory automatic cost and wage increases). Nor does the amount recommended by the Governor allow for the staffing of new buildings now being completed or for more personnel to treat more patients.

A bill before the House would provide state aid for vocational training centers for the mentally retarded. Another calls for a bond issue to acquire land for, construct and equip a mental health center in New Haven. In cooperation with the Yale Medical School, the center would provide diagnosis, treatment, research, out-patient service and part-time care for patients needing only day or night hospitalization.

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Gov. G. Mennen Williams of Michigan called for a mental health budget of $69,401,693—an increase of $4,234,943 over last year's.

He recommends $60,639,093 for the State Department of Mental Health, $6,612,600 for the hospitalization of patients in Wayne County, and $2,150,000 for mental health services at the University of Michigan (including $924,482 for the Neuropsychiatric Institute, $1,165,929 for the Children's Hospital and $365,790 for research).

The Michigan legislators are also considering adoption of the interstate compact on mental health, as well as a measure prescribing the civil rights of mental patients, outlining procedures for reimbursement of the costs of hospitalization in state institutions, and modernizing commitment procedures.

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Approval of a $43,152,000 mental health budget by the Texas legislature would mean $4.13 a day could be spent on the care and treatment of each patient—instead of the present $3.40 average in the state's mental hospitals.

This amount—requested by the Board of State Hospitals and Special Schools and supported by the Texas Association for Mental Health—would allow for 34 more doctors, 500 more nurses and attendants, 11 more psychologists and 29 more social workers.

Funds are also asked for 5 regional mental health centers in 1959–60 and for 10 centers in 1960–61. They would offer diagnostic and treatment services for emotionally disturbed, mentally retarded and handicapped children, and counseling for their parents. Personnel at the centers would also diagnose and treat disturbed adults, discharged mental hospital patients and alcoholics.

Of Texas' 254 counties, only 8 have community mental health clinics. According to the Texas Association for Mental Health, only the 13 counties with populations over 100,000 are able to finance clinic services for themselves.

This legislature is also considering a bill which would permit participation in the interstate compact on mental health.

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"Brains before bricks" is the slogan in South Carolina, where the legislature is urged to provide funds for much-needed psychiatric personnel. A special legislative committee recommended the appropriation of $400,000 for the expansion of psychiatric teaching facilities at the state medical college.

A concurrent resolution now under consideration would continue the work of a committee appointed to study the state's public and private mental health facilities and the laws relating to mental health.

This legislature is also considering ratification of the interstate compact on mental health.

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The Minnesota Association for Mental Health arranged for 21 members from 33 counties to testify before a state legislative committee on the need for a state appropriation of at least $739,000 to match funds that they either have raised or expect to raise for community mental health centers.

Expansion of local psychiatric facilities is an important part of the state mental health association's 9-point legislative program.

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Nine specific recommendations were made to the Florida legislature by the state mental health association. They cover:

- $1,000,000 for the construction of a much-needed 50-bed children's center on the grounds of South Florida State Hospital. There are 25 mentally ill children between 12 and 16 now on the wards with adults.
- $160,000 for interim care for these children.
- $4,173,000 to add 600 beds to the new 400-bed state hospital now nearing completion at Macclenny, near Jacksonville.
- $1,237,000 for capital expenditures at the largest state hospital at Chattahoochee.
- $465,000 for the Council on Training and Research in Mental Health, to be spent for staff specialists, research and scholarships.
- $1,483,000 for the State Board of Health's bureau of mental health, a good part of this for more mental health workers in county health departments and child guidance clinics.
- Legislation authorizing a 2-year experimental program of foster home care for up to 300 aged men and women too infirm to be in their own homes but not requiring nursing or hospital care. About 170 of them are in state mental hospitals and could be discharged at once if homes were available for them.
- Enough funds to increase the capacity of Sunland Training School in Lee County from 780 beds to 1,000.
- $400,000 for additions to the school, an auditorium and recreation building, at Sunland Training Center in Gainesville, plus sufficient funds for additions to the hospital and staff residences.

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Gov. Robert T. Stafford and the Vermont legislature received requests totaling $201,000 for mental health projects under the state's 2-year-old community mental health services law. The Vermont Association for Mental Health is urging the appropriation of at least this amount for the next biennium.

The association reports that Vermont lacks adequate clinics for its 7,000 emotionally ill children—about 8% of the school enrollment. There is also need for a psychiatric hospital unit for emotionally disturbed and mentally ill children requiring round-the-clock care.

The Vermont legislature is also considering a bill providing for the right of counsel for persons to be committed to mental hospitals.

A bill calling for ratification of the interstate compact is before the Vermont senate. Administration of the compact would be vested in the state commissioner of mental health.

Another measure would set up an Interdepartmental Board of Mental Health. The board would coordinate the mental health activities of 6 state departments—Health, Institutions, Social Welfare, Public Safety, Alcoholic Rehabilitation, and Education.

CARE AND TREATMENT

Extensive psychiatric procedures are now covered by the New York State workmen's compensation fee schedule. A new schedule which went into effect March 1 calls for higher fees and increases payments for rehabilitation procedures.

Psychiatrists are now allowed $25 for the initial interview, up to $200 for shock therapy and up to $225 for psychotherapy in the doctor's office or in a hospital. Under the old schedule they were paid only for the initial psychiatric interview, with the fee set at $15.

Rehabilitation specialists will now be paid for such services as psychosocial determination, vocational guidance, daily activities testing and physical and occupational therapy. Under the old schedule they were allowed only $25 for examination, observation and consultation.

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The National Institute of Mental Health reports that federal, state and local funds budgeted for community mental health services reached a new peak of $64,800,000 in fiscal 1959, 20% more than in 1958.

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A unique "big brother" system is being used by hospitalized veterans in their fight against mental illness, the Veterans Administration has reported.

Recovering patients at the VA mental hospital in Salisbury, N. C., have formed a society known as "The Helping Hand," in which each member holds himself responsible for more seriously ill patients in hospital activities, the VA said.

Dr. Samuel J. Muirhead, manager of the hospital, said the scheme has proved an effective form of help for both its members and non-members. Improved patients can help less fortunate patients towards recovery in ways that the hospital staff cannot, he said. Some patients, noting improvement in the condition of their companions, become aware that their own improvement is possible.

Membership in the society is restricted to patients approved by its screening committee and elected by unanimous vote.

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A day treatment unit for mentally ill children has been opened by the Henry Ittleson Center for Child Research in Riverdale, N. Y., in cooperation with the Interdepartmental Health Resources Board of New York.

The center now offers the seriously disturbed child and his family a comprehensive and flexible program of inpatient, outpatient and aftercare services, including individual and group therapy, education, psychological service, recreation and parent counseling.

The center accepts for treatment the seriously disordered child who has not been able to make a satisfactory adjustment in family life, school and community. Both boys and girls between 5½ and 8 years of age are accepted on a non-sectarian, interracial basis. Admission is not limited to any specific diagnostic classification, although children with obvious neurological deficits and with known mental deficiency and physical problems requiring special hospital care are not accepted.

A major criterion for admission is the availability and willingness of the parents to participate actively in the program.

Further information is available from Dr. William Goldfarb, director of the center, 5050 Iselin Ave., Riverdale 63, N. Y.

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The Office for Dependents' Medical Care of the U. S. Army has clarified its ruling on payment in cases of acute emotional disorders complicating maternity care.

During the antepartum period, Medicare says in-hospital care for eligible dependents may be authorized for limited periods if the emotional upsets "constitute an actual complication jeopardizing pregnancy."

To come under the Medicare program for in-hospital treatment of postpartum psychosis, admission must have occurred during the authorized 6-week postpartum period. The maximum government liability will be limited to the management of the acute phase.

Requests for payment of both hospitalization and doctors must include clinically detailed certificates signed by the attending physician or the physician providing psychiatric treatment. The certificates must also indicate that the patient's illness was in an acute phase from the time of admission through the period covered by the claim.

No payment is authorized for pseudocyesis or its management, or for outpatient care for acute emotional disorders.

Local contractors may pay claims when the hospitalization does not exceed 21 days. When management of the acute phase is expected to exceed this limit, prior approval of payment for any additional care must be obtained from the contracting officer, Office for Dependents' Medical Care, Office of the Surgeon General, U. S. Army, Washington 25, D. C.

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In cooperation with the American Psychiatric Association, the National Association for Mental Health is co-sponsoring a 2-year study of insurance coverage for psychiatric illness, a project of Group Health Insurance, Inc. The investigation is being financed with a $300,000 grant from the National Intitute of Mental Health and with $150,000 in Group Health Insurance funds.

The total amount is expected to pay for psychiatric services to 1,500 patients in the New York City area and to cover the cost of organizing the study and evaluating the findings.

The new services will be available at no extra cost to about 77,000 individuals—30,000 GHI subscribers and their dependents—divided about as follows: 50% unskilled or semi-skilled, 25% clerical, 17% skilled, 4% executive and 4% professional. All were enrolled before there was any announcement of the psychiatric project.

Under the plan, those needing psychiatric service may receive:

- Up to 15 sessions of individual psychotherapy in a doctor's office, with GHI paying $15 per session and the patient paying $5.
- Group psychotherapy up to a maximum, in combination with individual therapy, of $225. GHI will pay $3 per group session and the patient will be expected to pay $1.
- Anesthesia at $10 per treatment, if a specialist other than a psychiatrist gives electroshock therapy.
- Psychological tests to a maximum of $45 if prescribed by a psychiatrist and given by a licensed psychologist.

* * *

A new departure in psychiatric treatment has been undertaken by the Veterans Administration.

The agency's first mental hygiene day center for the treatment of veterans with service-connected mental illness was established recently at the VA outpatient clinic in Brooklyn, N. Y. The VA expects that more of its mental hygiene clinics will establish similar centers within the next few years.

The day center program is designed primarily to provide more and better outpatient treatment for the increasing num-

ber of veterans being released from VA hospitals after treatment for service-connected schizophrenia. Many of these veterans recovering from schizophrenia need a great deal of help through the VA outpatient treatment program if they are to adjust to community living and avoid rehospitalization.

The Brooklyn clinic director, Dr. Philip R. Casesa, said some 75 patients will spend the major part of their time at the new day center in a therapy and planned living program under supervision of psychiatrists, psychologists and social workers.

In addition to individual and group psychotherapy and educational and occupational therapy, this program will include social and recreational activities carried out with the assistance of volunteers from the community.

In contrast, the regular VA outpatient mental treatment program provides for about two hours of psychotherapy per patient at a VA clinic weekly.

New tranquilizing drug therapies and improved treatment programs are increasing the number of patients being released from VA mental hospitals, especially the number of those being released after hospitalization for schizophrenia.

The day center is part of VA's continuing efforts to explore new methods of psychiatric rehabilitation. Other programs include:

1. Return of selected patients to communities through foster-home care.

2. Return of patients to the community at night after daytime treatment, or to daytime jobs in the community with treatment at night.

3. Selection of long-term mental patients for salaried employment at VA hospitals, to condition them for normal work and social life.

These programs are designed to help the patient make a smooth transition from hospital to home environment. Emphasis is placed on group therapy, resocialization techniques and other rehabilitation methods.

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A 20% increase in the number of veterans with severe mental illness recovering and leaving Veterans Administration hospitals on trial visits to their home communities was reported by the agency in April.

The VA said its hospitals placed 8,076 mental patients on trial visits during the first six months of fiscal 1959. This is a 20% increase over the 6,736 patients placed on trial visits from VA hospitals during the first six months of fiscal 1958.

The 13,332 placed on trial visits during fiscal 1958 is only a slight increase over the 13,200 in fiscal 1957 but is an 8% increase over the 12,351 in fiscal 1956, a 34% increase over the 9,985 in fiscal 1955, and a 75% increase over the 7,617 in fiscal 1953.

Most of the patients leaving the hospitals on trial visits have been treated for severe mental conditions, the VA said.

The average daily patient load of mentally ill veterans in VA hospitals has remained at around the same number since the beginning of fiscal 1956, following an increase between 1953 and 1956. Currently, the figure is 57,103, which includes 51,871 veterans with severe mental illness and 5,232 with less severe psychiatric disorders.

The VA said the increase in patients on trial visit can be attributed to changes in therapies (including use of tranquilizing drugs and more emphasis on individual and group psychotherapy), to an increase in open wards, and to reawakened interest in development of new habits of resocialization to prepare patients for return to community living.

TRAINING

The 100th mental health in-service training grant has been awarded by the Southern Regional Education Board, according to Dr. Paul W. Penningroth, SREB assistant director for mental health and director of the grant program.

The grants have been awarded since June 1958 to enable employees of mental hospitals and training schools in the South to study care and treatment in institutions anywhere in the country. Awards up to $500 are made to cover transportation, room and board for four weeks or less.

"These visits are made possible so that anyone working in a mental institution can observe first-hand a new or better way of doing his job," Dr. Penningroth said.

An average of $245 has been awarded to mental health personnel in 11 southern states. Physicians, nurses, social workers, therapists and educators have received most of the grants, but a wide variety of other specialities are represented including hospital chaplains, librarians, food service managers, ward attendants and volunteer coordinators, among others.

Grantees have gone to many different institutions in 22 states and Canada. More than half of the visits were made to New York, Kansas, Connecticut, the District of Columbia and Pennsylvania.

Funds for the 2-year grant program were provided to the SREB by the National Institute of Mental Health. Applications for grants are being accepted continuously until June 1960. Inquiries should be addressed to Dr. Penningroth at the Southern Regional Education Board, 130 6th St., N.W., Atlanta 13.

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The University of Cincinnati College of Nursing and Health offers programs preparing clinical specialists in both adult and child psychiatric nursing which lead to the degree of Master of Science in Nursing.

The program for clinical specialists in child psychiatric nursing prepares psychiatric nurses to work with individuals and small groups of emotionally disturbed children in psychiatric inpatient residential treatment centers. The 3-semester program includes intensive study of child growth and development and of dynamic psychiatry, along with guided field work in a residential child treatment home, state hospital children's inpatient service and other community agencies.

The program for clinical specialists in adult psychiatric nursing is focused on developing an expert practitioner to work effectively with patients individually and in groups. Opportunities are available for the study of the psychodynamic aspects of the patient's illness for interdisciplinary participation in the treatment of patients and for the investigation of clinical problems in psychiatric nursing.

Further information is available from the director of the university's programs for graduate nurses, 426 College of Pharmacy Building, Cincinnati 21, Ohio.

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A teaching film, "Psychiatric Nursing: The Nurse-Patient Relationship," is available from Smith Kline & French Laboratories, Philadelphia. Designed as a service to the nursing profession, it was sponsored by the mental health education unit of SKF and produced cooperatively by the SKF medical film center and the American Nurses' Association and National League for Nursing.

PUBLIC INFORMATION

The intensive public education campaign waged by the National Association for Mental Health and its affiliates in the last

few years is beginning to pay off, according to Harry Milt, public relations director.

Dramatic testimony to the campaign's effectiveness is provided in the results of a recent Elmo Roper poll. It showed that next to education, the American people are most willing to be taxed to pay for the care and treatment of the mentally ill.

To a nation-wide sample of the adult population Roper interviewers put this question: "Here is a list of things that are paid for by tax money. Would you be willing to see taxes raised so that more money could be spent on any of the things on this list? Which things?"

Those polled answered: "Public schools 36%, mental institutions 32%, social security benefits 24%, unemployment compensation 17%, police and law enforcement 14%, streets and highways 13%, prisons and reformatories 9%, public sanitation and garbage disposal 7%, parks and recreation facilities 6% and postal service 3%."

Commenting on these percentages, the Roper Associates said: "That public schools come out first on the list of items the public wants to see more money spent on is perhaps not surprising. The number two item is more surprising.

"The frequent mention of mental institutions is dramatic testimony to the effectiveness of recent public education campaigns on the need for adequate care and treatment of the mentally ill."

The poll was taken last October and the results published in December.

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A psychiatry class for lawyers, believed to be the first of its kind in the U.S., has been set up by the Mental Health Association of San Mateo, Calif. More than 30 practicing attorneys enrolled for the 8-week course, co-sponsored by the College of San Mateo and the Bar Association.

The Dallas Association for Mental Health and Junior Bar Association are also sponsoring a program designed to give attorneys a better understanding of the various types of mental illness and their manifestations.

AWARDS

Dr. Donald Ewen Cameron of McGill University, Montreal, president of the Canadian Psychiatric Association and past president of the American Psychiatric Association, is the 1959 recipient of the $2,500 Samuel Rubin award for outstanding achievements in mental health. The award was presented April 17 in New York City.

Dr. Cameron was selected for the award by a professional committee under the chairmanship of Dr. Lewis R. Wolberg, medical director and dean of the Postgraduate Center for Psychotherapy in New York City, a non-profit organization which provides therapy for persons of low income and conducts advanced training and research programs in psychotherapy.

Dr. Paul R. Hoch, New York State mental hygiene commissioner and first recipient of the award in 1957, made the presentation for the Samuel Rubin Foundation.

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Irving L. Janis, Ph.D., associate professor of psychology at Yale University, is winner of the American Psychiatric Association's $1,500 Hofheimer prize for research for 1959, it was announced in May at the APA's annual meeting in Philadelphia.

Dr. Janis was selected by a board of six APA fellows for research described in his book *Psychological Stress: Psychoanalytic and Behavioral Studies of Surgical Patients.* On the basis of his studies he hypothesized that "in adult life, exposure to any signs of potential mutilation or annihilation will tend to reactivate the seemingly outgrown

patterns of emotional response which had originally been elicited and reinforced during the stress episodes of early childhood." In extensive preoperative and postoperative interviews with surgical patients Dr. Janis elicited much data of potential usefulness in preparing patients psychologically for surgical stress.

A native of Buffalo, the 41-year-old researcher received his B.S. degree from the University of Chicago in 1939 and his Ph.D. from Columbia in 1949. He has held numerous fellowships and research awards from the Social Science Research Council, New York Psychoanalytic Institute and Ford Foundation, and a Fulbright research award. He has made many contributions to psychiatric and psychological literature since 1943. He was a joint author with Samuel A. Stouffer of the classic study entitled *The American Soldier* published in 1949.

The Hofheimer prize was established in 1947 in honor of Lt. Lester N. Hofheimer of New York City, who lost his life in action in the Mediterranean in World War II. The recipient must be under 40 at the time the research is submitted for publication.

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Dr. Maxwell Jones, eminent British psychiatrist, is the eighth winner of the American Psychiatric Association's $1,000 Isaac Ray award, given annually to a psychiatrist or member of the bar for furthering understanding between the two professions.

As recipient, Dr. Jones will deliver a series of lectures on psychiatry and the law at George Washington University in Washington, D. C., in the next academic year under the joint auspices of the university's law and medical schools.

Dr. Jones is especially noted for his success in treating and rehabilitating adults with personality disorders of the anti-social type at Belmont Hospital in Sutton, Surrey, England, where he directs the social rehabilitation unit. He has been a foremost leader in developing the concept of the mental hospital as a "therapeutic community." The concept emphasizes the functioning of the hospital as a social system. The typical therapeutic community stresses open doors, patient government, democratic group participation and related practices as part of the total treatment program. It operates on the premise that where good and reasonable behavior is expected, patients will respond to the expectation.

Since 1949 Dr. Jones has been on the council of the Institute of Human Relations at Tavistock Clinic in London. His major work, *The Therapeutic Community* was published by Basic Books in 1953. He is a corresponding fellow of the American Psychiatric Association.

The award commemorates Dr. Isaac Ray, a founder of APA, whose remarkable *Treatise on the Medical Jurisprudence of Insanity,* published in 1838, was for many years the standard work on the subject.

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The *Pharos-Tribune* of Logansport, Ind., has been adjudged the winner of the 1959 National Mental Health Bell Award in recognition of its consistent editorial support in the fight against mental illness. The award was presented at special ceremonies of the Indiana Association for Mental Health.

A special citation of merit to the Albany, N. Y., *Knickerbocker News* also was awarded by the Mental Health Bell Award committee for that paper's sustained and successful editorial efforts in bringing about the establishment of the Albany County Mental Health Board. The citation was presented May 17 in Albany at a dinner meeting during the 4th annual conference

of the New York State Association of Community Mental Health Boards. Robert Barrie, executive director of the New York State Society for Mental Health, made the presentation on behalf of the National Association for Mental Health, the Albany County association and the New York state society.

Selection of the *Pharos-Tribune* was based on its year-round coverage of developments in the field of mental illness, advocacy of improvements in the treatment and prevention of mental illness, and editorial support of the program and activities of the mental health associations.

The Mental Health Bell Award is presented each year to an American daily newspaper which during the preceding year made an outstanding contribution to the fight against mental illness. The bronze plaque is a replica of the historic 300-pound Mental Health Bell cast in 1953 from chains and handcuffs formerly used to restrain mental patients.

Other American newspapers which have won the award are the Columbus, Ga., *Enquirer,* 1958; *Arizona Republic,* 1957; Austin, Texas, *American-Statesman,* 1956; *Indianapolis Times,* 1955; *Hartford Courant,* 1954; and Baltimore Sunpapers, 1953.

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"Bitter Welcome," a new film about the problems of the returning mental patient, was awarded a blue ribbon as the best mental health film of the year at the Educational Film Library Association's film festival.

APPOINTMENTS

Dr. Warren T. Vaughan, director of the children's unit, at Metropolitan State Hospital in Massachusetts, has been appointed director of the mental health program of the Western Interstate Commission for Higher Education. His office will be located at the WICHE headquarters on the University of Colorado campus in Boulder.

The commission is a regional public agency set up by 12 western states to promote regional cooperation in higher education. The WICHE mental health program is concerned with training and research and is financed through a grant from the National Institute of Mental Health.

As the head of this project, Dr. Vaughan will direct his efforts toward the development of programs to increase the West's supply of mental health personnel and to promote research in mental health.

According to Dr. Harold Enarson, executive director, "Dr. Vaughan's training and background make him eminently qualified to direct this mental health work in the West. As a psychiatrist who has been concerned with community mental health services for many years, he will bring to his work an ideal combination of experience in administration, teaching, psychiatric practice and research."

From 1953 to 1957 Dr. Vaughan served as director of the division of mental hygiene in the Massachusetts Department of Mental Health. In this capacity he developed a state-wide program of community mental health services that received national recognition. Since 1953 he has been on the faculty of the Harvard School of Public Health. He has served for 10 years as a consulting psychiatrist for several school systems in Massachusetts. Last year he completed an assignment as associate director of a task force of the Joint Commission on Mental Illness and Health.

In the field of research Dr. Vaughan has directed a state survey of community mental health resources in Massachusetts and a study of psychiatric services in Con-

necticut general hospitals. He has written widely in the fields of community and school mental health. He is currently engaged in an analysis of day hospitals for children.

During World War II Dr. Vaughan served as a captain in the Medical Corps immediately following his graduation from Harvard Medical School.

Dr. Vaughan succeeds Dr. Daniel Blain, former medical director of the American Psychiatric Association, who recently resigned to become director of the California Department of Mental Hygiene.

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Sidney Spector of Chicago, director of the Interstate Clearing House on Mental Health, has been appointed staff director of the Senate subcommittee on problems of the aged and aging. He has filled many important posts for the Council of State Governments and the Governors' Conference and has written a number of significant reports on mental health conditions in the U.S.

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Dr. Roger W. Howell of Detroit has been appointed associate professor of public health administration at the University of Michigan. He joins the School of Public Health in July as its first full-time psychiatrist.

Since 1956, Dr. Howell has been director of preventive psychiatry at the Lafayette Clinic in Detroit and associate professor of psychiatry at Wayne State University.

MEETINGS

Dr. Jack R. Ewalt, director of the Joint Commission on Mental Illness and Health, will give the keynote speech at the opening general session of the 9th annual meeting of the National Association for Mental Health, set for November 19 in Philadelphia.

The meeting will mark the 50th anniversary of the formation of a national citizens' mental health organization.

Dr. Ewalt will touch on four general topics: better care and treatment for hospitalized mental patients, rehabilitation services, services for emotionally disturbed children, and research in mental illness. Each will be discussed in detail in subsequent half-day workshops or general sessions.

Also on the schedule are regional dinners focusing on the need for more funds for services to the mentally ill; curbstone conferences on fund-raising, field service, public relations, education, volunteer services and mental health education; breakfast-time film showings; and four business sessions, two for the NAMH board and two for the membership.

The annual banquet, set for November 20, will take as its theme "Fifty Years of Progress in the Fight against Mental Illness."

A summing-up and a look to the future will be provided by a speaker of eminence at a final luncheon November 21.

Preceding the annual assembly will be a national institute sponsored by NAMH for executive directors and other staff members of state and local mental health associations. It is scheduled for November 16–18, also in Philadelphia.

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"New Horizons in Psychiatry" will be the theme of a divisional meeting of the American Psychiatric Association October 29–31 in Detroit.

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The annual meeting of the National Council on Family Relations will be held

August 19–21 at Iowa State College, Ames. The theme will be "Growing Individual Values within the Family."

In additon to general sessions with outstanding speakers, there will be sessions on cooperative nursery schools, research, parent education, religion, counseling, and family life education in the community, schools and colleges, according to Dr. Aaron Rutledge, president-elect and program chairman.

Attendance is open to all. Further details are available from the council, 1219 University Ave., S.E., Minneapolis 14.

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The 17th annual meeting of the American Psychosomatic Society will be held March 26–27, 1960 in Montreal.

Taking office at the last annual meeting, held May 2–3 in Atlantic City, were Dr. Eric D. Wittkower, president; Dr. Morton F. Reiser, president-elect, and Dr. Eugene Meyer, secretary-treasurer. Elected to the council were Drs. George L. Engel, David A. Hamburg and David R. Hawkins.

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Dr. Robert H. Felix, director of the National Institute of Mental Health, has been named president-elect of the American Psychiatric Association. He will take office next May.

At the recent APA meeting in Philadelphia, Dr. William Malamud, research director for the National Association for Mental Health, assumed the presidency, to which he was elected last year.

Other APA officers include Dr. Franklin G. Ebaugh of the University of Colorado School of Medicine and Dr. Spafford Ackerly of the University of Louisville School of Medicine, vice-presidents; Dr. C. H. Hardin Branch, University of Utah School of Medicine, re-elected secretary; Dr. Addison M. Duval of the Missouri Department of Public Health and Welfare, treasurer; Dr. Paul H. Hoch, New York's mental hygiene commissioner, Dr. A. B. Stokes of the University of Toronto School of Medicine and Dr. Calvin S. Drayer of the Institute of the Pennsylvania Hospital, councillors.

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Dr. Edward L. Bortz, formerly president of the American Medical Association, leader in geriatrics, and now chief of medical service at Lankenau Hospital in Philadelphia, has been named chairman of the 1960 National Health Forum.

The forum, an annual national conference, is sponsored by the National Health Council on behalf of its more than 60 member agencies. The 1960 forum will be held in Miami Beach the week of March 13. Discussions will center on the health of old people.

"The annual National Health Forums enable leaders in health and other organizations to consider together an important national problem which requires public and professional attention and action by many groups," Miss Ruth Freeman, council president, said. "The health problems of the aging need to be analyzed and call for individual and community action. They involve social as well as economic and psychological considerations. Solutions depend upon mutual study and action by many groups in addition to the medical and related health professions."

PUBLICATIONS

The contributions—past, present and potential—of volunteers in advancing the treatment and care of mental patients are comprehensively set forth in a new book called *The Volunteer and the Psychiatric Patient.*

It is based on a conference held last June in Chicago under the auspices of the National Association for Mental Health, American Psychiatric Association, National Institute of Mental Health, American Hospital Association, Veterans Administration and American Red Cross.

The book tells what volunteers do and where they do it; how they are recruited, screened, trained and supervised; how volunteer programs are administered; and what potential exists for expanding the use of volunteers outside hospitals.

A feature of the book is a bill of rights for mental patients. It was drafted by Dr. John J. Blasko and endorsed by the conference as useful in calling attention to specific needs and rights of the mentally ill. The book also contains helpful statistics, lists of agencies which supply volunteers, sample job descriptions, reading lists and so on. It is available for $2.50 a copy from the APA, 1700 18th St., N.W., Washington 6, D. C.

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Tax and fiscal problems underlying state mental health and hospital programs are analyzed in a new monograph published by the American Psychiatric Association. It was written by Sidney Spector, known to mental health associations throughout the country as director of the Interstate Clearing House on Mental Health.

Copies of *Tax and Fiscal Policy and State Mental Health Programs* are available free from the APA, 1700 18th St., N.W., Washington 6, D. C.

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The April 1959 issue of the *American Sociological Review* was devoted almost entirely to articles on deviant behavior. Among the titles and authors were "Deviant Behavior and Social Structure: Continuities in Social Theory" by Robert Dubin, "Illegitimate Means, Anomie and Deviant Behavior" by Richard A. Cloward, "Social Conformity, Deviation and Opportunity Structures: A Comment on the Contributions of Dubin and Cloward" by Robert K. Merton, and "Antisocial Sentiment and Criminality" by Gwynn Nettler.

Copies are available for $2 each from the American Sociological Society, New York University, Washington Square, New York 3.

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Growing Up in a Changing World is a compilation of papers presented at the 10th annual meeting of the World Federation for Mental Health, held in Copenhagen in 1957. The volume is available from WFMH, 162 E. 78th St., New York 21, for $2.50.

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A new consultation service for the planning, designing and equipping of psychiatric facilities has been instituted by the American Psychiatric Association. It is available to architectural and engineering firms, heating and lighting experts, equipment and furniture manufacturers, community organizations, government agencies, hospital planning commissions and other interested groups.

The architectural service staff will make available a considerable collection of information and material on the construction of public and private psychiatric hospitals, psychiatric units in general hospitals, mental health clinics, day and night hospitals, half-way houses, sheltered workshops, residential units for children and special facilities for the aging.

One of the service's first contributions is the publication of *Psychiatric Architecture,* a 156-page review of contempo-

rary developments in the field. In addition to 45 color pictures of mental hospitals abroad, the book contains extensive glossaries, a check list for planning construction, and contributions by 24 psychiatrists and architects. It is available for $10 a copy from the APA, 1700 18th St., N.W., Washington 9, D.C.

MENTAL RETARDATION

In the judgment of the Council of State Governments, one of the urgent problems facing every state today is that of formulating and carrying out a coordinated, comprehensive program of services for the mentally retarded.

Two years ago the council formed a committee on mental retardation, composed of some of the nation's leading students and practitioners in the field. This committee has given special attention to developing guides for the states in organizing effectively to meet the problems of the mentally retarded.

To assist in its deliberations, the committee called a conference on mental retardation November 20–21, 1958 in New York City, with representatives from many fields and from all sections of the country. After two days of intensive discussion and after further critical review by the committee, a series of recommendations were adopted on state organization, modernizing commitment legislation and financing programs for the mentally retarded.

The report and recommendations of that conference follow:

Statement of Purpose

On November 20–21, 1958, the committee on mental retardation of the Council of State Governments called a special conference of outstanding leaders in the field of mental retardation, to develop a comprehensive program for guidance to the states.

In few areas of state government has there been such intense pressure in recent years for the enactment of an effective program to meet the needs of the mentally retarded—young and old. State institutions at present are heavily overcrowded with more than 140,000 residents of all ages and of varying degrees of retardation and mental defect. Buildings are obsolete, archaic and unsuited for a modern treatment program in many instances. Waiting lists for entry into institutions have reached heart-breaking—in fact, politically sensitive—proportions. Thousands of educable and trainable retarded people are receiving no education and no training, and little care. Diagnostic facilities are scarce, and personnel trained and qualified to work in the field is even rarer.

And yet, one of the nation's top research scientists in the field of mental retardation stated that if we did everything we could possibly do today, based on the knowledge that we have today, we probably would prevent *at least* one-half of the cases of mental defect and mental retardation that we know will occur.

As a result, parent groups, relatives of families with retarded children, people with interest and concern for a handicapped group as well as taxpayers visualizing large and costly building programs have focused national attention on this problem to the highest degree that we have known.

Governors and legislators and other state officials as never before are attempting to meet the needs of the mentally retarded and are seeking advice and guidance on how best to organize effective, comprehensive state programs to prevent mental retardation, where possible, to deal with it early, when needed, and to provide voca-

tional and educational facilities in order to keep as many in the community as possible.

It was to assist in responding to this overriding question that the Council of State Governments called this 2-day conference of experts from the fields of education, welfare, health, mental health and employment, and from state government, the federal government and the universities. Included also was a substantial number of legislators from as far west as Oregon and California to as far east as Connecticut, New Hampshire and New York. All of them knew well the problems of the mentally retarded, following long, serious study and reports as members of legislative committees.

Out of these two full days of lectures and intensive discussion, the conference developed a set of recommendations designed to assist the states in dealing with the following three major questions:

1. What kind of administrative organization is required by the states to carry out a comprehensive program in the field of mental retardation?

2. What kind of legislation should our states pass to modernize their commitment and discharge procedures?

3. What financial arrangements are necessary to execute a comprehensive program?

State Administrative Organization

The problems of the mentally retarded are not and cannot be the sole responsibility of any one department of state government. They are important concerns of several departments and require a multiple but coordinated attack.

1. The conference therefore recommended that each state establish an interdepartmental agency, such as an interdepartmental committee, council or board, for the joint planning and coordination of state services for the mentally retarded. This interdepartmental agency may be established by the Governor or the legislature, depending upon conditions prevailing in the state.

2. Such departments as education, mental health, health, welfare, labor, corrections and institutions of higher education offer programs and services for the mentally retarded. Within a given state there may be other departments concerned with the mentally retarded. Within each of these departments there should be a division or bureau for services to the mentally retarded or a special consultant with specific responsibility for the development and administration of these services.

3. In order to implement these recommendations, the conference recommended that:

Each department head or his deputy should report to the interdepartmental agency on the responsibility of his department for services to the mentally retarded and on the extent to which these services are provided.

The interdepartmental agency should submit reports periodically, with recommendations for legislative and administrative action to improve services for the mentally retarded.

4. A comprehensive program for the mentally retarded should include intensive efforts to prevent mental retardation in the first place. This means: services to prevent birth defects, prenatal care, pediatric care, child health supervision and safety provisions. The state program should also include diagnostic services for development evaluation, an extensive research effort, provisions for the training of professional personnel, and intensive programs for the care, training and welfare of the mentally retarded.

5. To increase the efficient use of per-

sonnel and facilities in research, training and treatment, the states should explore the potential of pooling resources within regions for cooperative interstate efforts.

6. Wherever possible, services for the mentally retarded should be provided at the community level, with state assistance where needed. State provision should complement services provided at the community level.

7. Any program providing a comprehensive approach to the problems of the mentally retarded must include provision for joint planning between state agencies and local government agencies.

8. Particular attention should be given to the problem of providing appropriate services to the mentally retarded in the rural areas of the states.

9. An effective program for the mentally retarded will give emphasis to services for very young children.

10. Lay groups concerned with the problems of mental retardation should participate in an advisory capacity to those agencies established by the state to deal with the problem.

Modernizing Commitment and Discharge Legislation

The conference adopted the view that major emphasis should be placed on voluntary admissions to institutions for the mentally retarded, rather than judicial proceedings.

The conference recognized that judicial commitments will still be required for a small group of mentally retarded individuals who also are afflicted with severe behavior disorders.

These instances, however, will be relatively few, and the whole trend, the conference agreed, is in the direction of early voluntary admissions and intensive treatment.

1. Judicial Commitment. When judicial commitment is applied for, provision should be made for referring the case to appropriate community resources for diagnostic evaluation. These community resources should consist of persons competent to make medical, psychological and social evaluations.

The total evaluation should consist of the determination as to whether or not the person is mentally retarded and is suitable for and in need of institutional care.

Upon receipt of the report of evaluation, the court should be required to reject the petition if the evaluation is negative. The court, however, should have jurisdiction to commit or not commit in the event that the evaluation is affirmative.

If the court determines that commitment should be made, it must communicate with the authorities of the proper agency to which it proposes to commit with respect to the availability of space and facilities for the person; if the report from the agency is in the negative, the court must withhold commitment until advised by such authorities that space and facilities are available.

The authorities of an institution should be authorized to take such action with reference to release, parole or other action with regard to a committed behavior problem child which they deem appropriate as in the case of any other committed patient; but in the event such authorities are of the opinion that the child properly belongs in another type of institution they shall be permitted to apply to the committing court for revocation of such commitment and for commitment to another institution.

The commitment should not constitute an adjudication of incompetency for any purpose other than institutionalization.

2. Voluntary Admission. The same process of evaluation in a community diagnostic facility competent to make medical, psychological and social evaluation should be a prerequisite to voluntary admission as is provided for under judicial commitment.

Upon application of the parent or guardian and after evaluation which determines that the child should be admitted, a certificate of admission should be executed by the evaluating resource, which would confer jurisdiction on the authorities of the institution or hospital to hold for care and treatment and to return from unauthorized leave any person granted admission, provided that such person shall not be retained for more than 30 days after the receipt of a request from the parent or guardian of a person under maturity age, or the person himself after reaching maturity age or any relative or friend on his behalf, for release of such person. Within such 30 days, the authorities of the institution or hospital may petition for judicial commitment, and such release shall be withheld pending the decision of the court.

Financing an Effective Program

1. Research. The conference adopted the principle that research in the field of mental retardation is essential, and no state program can be effective without devoting state funds for this purpose. In order to establish a productive research effort, including research in prevention, state funds are required to provide a core staff of investigators who can look forward to long-term research activity. Furthermore, mental retardation is uniquely a problem for state governments, and research is essential to evaluate how well the states are carrying on their own programs.

The conference therefore recommended that every state appropriate funds for research in the field of mental retardation and that these funds should be made available on a continuing basis for use in a flexible manner. Funds for research can be provided through investing a portion of the fees paid by financial responsible relatives into a research fund dedicated for this purpose.

2. Relative Responsibility. The committee recommended that the states should adopt the principle that parents or responsible relatives financially equipped to pay for the care of their mentally retarded should do so. However, safeguards should be written into the law to ensure that in no instance will such payment cause financial hardship to the family.

It also was recommended that the states should review their payment legislation and consider the possibility of setting some maximum related to the cost of care as the basis for payment.

3. State-Local Sharing in Cost of Education. The conference felt that communities should provide suitable education and training for every child and that incentive programs are needed, financed in part by the state, to ensure the education and training of the special categories which require heavier financial investment.

The conference therefore recommended that every state adopt mandatory legislation for the education of the educable mentally retarded and at least permissive legislation for the trainable mentally retarded and that the state assume the obligation of paying the local school district or community for the additional cost involved in the provision of these educational programs.

4. Departmental Services. The conference felt that state health, employment, corrections and welfare agencies providing

various services for children and adults should include the mentally retarded in the services that they provide, in order to achieve the most efficient use of existing resources.

The conference therefore recommended that these agencies, whether community or institutional, include the mentally retarded in the services provided by them. It further recommended that increased appropriations should be made available to these employment, health, corrections and welfare agencies and that the funds should be budgeted for the purpose of services to the retarded, at least initially.

5. Personnel. The conference agreed that personnel employed in state institutions for the mentally retarded, although devoted to their work and highly trained in many instances, generally have a lower level of employment prestige and that special financial inducements are required to raise the prestige of employment in the institutional system.

The conference therefore recommended that competitive salaries be provided for personnel trained in the field of mental retardation and that special inducements should be offered in order to attract and retain the best qualified personnel. In the long run, the conference felt, this step would be most efficient and economical.

The conference further recommended that state and federal funds be provided to training centers for academic training, at advanced levels, of personnel in the field of mental retardation. A great need, the conference felt, was the training of teachers and others who in turn could train other personnel.

The conference further recommended that state agencies concerned with mental retardation develop and carry out programs of in-service training for non-professional personnel and that funds be made available for this purpose.

6. Hill-Burton Funds. The conference recommended that Hill-Burton funds be increased generally and be made available for the construction of institutions for the mentally retarded.

7. State-Local Finances. The conference agreed that to every extent possible services for the mentally retarded be community-based. In many instances this will mean financial assistance by the state for such community facilities as day care centers, recreation activities, sheltered workshops, educational facilities, etc.

The conference therefore recommended that provision be made for states and communities to share in the cost of providing community facilities for the retarded, both for non-profit and public agencies but under full and ample supervision by the state.

8. Maternal and Child Health Grants. The conference recommended that federal maternal and child health grants should not be limited to public health departments but should be made available more flexibly to the agencies designated by the state.

9. Cost Projections. The conference recommended that the states develop plans and project their costs for the next ten years with respect to their building programs and operations on the basis of the best current thought in the field. This would require careful consultation with leading experts as to the best knowledge available today and the cost involved in putting this knowledge into effect.